WHAT'S THE LINK: AN EXPLORATION OF RECOVERY AND SOCIAL SUPPORT FOR INDIVIDUALS LIVING WITH A MENTAL ILLNESS

by

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Abstract

Recovery from mental illness is a personal journey of transformation and has been found to be a deeply social process (Anthony, 2000; Deegan, 2001; Jacobson & Greenley, 2001). The intent of this research was to explore the relationship between an individual's recovery journey and social support for people living with a mental illness. Through the use of two scales, 35 participants provided quantitative data (phase one). From the quantitative data, a qualitative interview guide was fine-tuned, which was used for 10 one-on-one interviews (phase two). The qualitative data was analyzed using a thematic analysis, and the following five themes emerged: Work/volunteer opportunities; Mental Health Services; Peers; Connectedness; and Stigma. Through conducting this research, a better understanding of the relationship between the recovery process and social support was achieved, as well as the beginnings of a consumer definition of social support.

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DEDICATION

This work is dedicated to those who live with a serious and persistent mental illness and face life and its circumstances every day by rising to the challenge of living a meaningful life.

Introduction

> "Although the world is full of suffering, it is also full of overcoming it" (Capponi, 2003, p. 117).

Whether people realize or not, it is suspected that mental health issues affect every single Canadian, either directly or indirectly (Canadian Mental Health Association [CMHA], n.d). Statistics suggest that one in four people has a mental health concern, and more specifically, ten percent of people live with a serious and persistent mental illness (SPMI), such as schizophrenia, bipolar disorder, schizo-affective disorder, or major depression (CMHA). In Prince George, BC, Canada, alone that statistic would suggest approximately 8,000 people live with an SPMI.

Every day, individuals living with an SPMI are marginalized and stigmatized, yet demonstrate tremendous personal strength and courage as they face a multitude of challenges while living in the community. Nearly four decades ago, individuals were not afforded this same opportunity of living among the general population, as many people living with an SPMI were institutionalized. Institutionalization "represented both an attempt to compensate for public disorder in a particular setting and to demonstrate the correct rules of social organization" (Rothman, 1990, p. 154).

Today, individuals are residing in the community and many are engaging in recovery, which is a personal journey or experience of transformation (Deegan, 2001). It has also been noted that recovery is a profoundly social process (Jacobson & Greenley, 2001). Baumeister and Leary (1995) assert this point in the following way: "Social relationships are a universal, fundamental human need almost as powerful as the need for food, which if not satisfied, could thwart positive psychological development and adjustment" (as cited in Pernice-Duca, 2005, p. 11).

Chapter One: Establishing the Basis

Research: Rationale and Purpose

The subject of mental health and mental illness has always been of interest to me, but my professional interest solidified when I pursued a bachelor's degree in psychology, and then worked with children with serious emotional and behavioural problems due to persistent abuse and neglect. Afterwards, I worked as a mental health counsellor, and supported individuals with varying problems in a small northern community. From the mental health counselling position, I began to work for CMHA, where I have had the honour of working for the past eight years, supporting adults living with serious and persistent mental illnesses. My time at CMHA has been one of growth, both personally and professionally. Personally, I have grown into the caring, passionate, driven advocate that I am today. Professionally, my practice framework has become defined, shaped, and strengthened by incorporating the belief of recovery. Briefly defined, recovery is suggested by the literature as the unique personal journey, complete with triumphs and setbacks, of learning to live a satisfying life through the creation of new patterns of behavior, despite the imposed limitations of living with an SPMI (Anthony, 1993; 2000; Deegan, 1988; 2001).

At CMHA, my job was to manage housing and lifeskills support programs, which assist adults living with an SPMI to reside semi-independently in the community. The housing program encompasses a five-bed group residence and 19 apartments, for which I acted as the landlord. I also sat as the chairperson for the housing committee that selects appropriate tenants for the housing program. The lifeskills component helps individuals learn and practice lifeskills, enabling individuals to live in the community. I was the supervisor of a six-person staff, that follows through on the individualized service plans, developed with

the individuals, to best meet their goals.

Therefore, it is from the people whom I have had the opportunity to serve at CMHA that I have gained my key knowledge, and ultimately gleaned my research question. Through my personal observations, I have recognized what appears to be helpful to individuals living with an SPMI in the community. Based on this information, I have realized that social support seems to be crucial to an individual's mental health recovery journey.

Augmenting my direct experience, the literature also suggests that recovery from mental illness is positively impacted by social support, and that having social supports in place has helpful effects on individuals living with an SPMI (Bradshaw & Haddock, 1998; Clinton, Lunney, Edwards, Weir, & Barr, 1998; Corrigan & Phelan, 2004; Pernice-Duca, 2005; Rogers, Anthony, & Lyass, 2004; Sullivan & Poertner, 1989). Despite literature being written about mental illness, recovery, and social support exclusively, there seems to be limited research examining the recovery process and its relationship with social support. Thus, through collecting quantitative and qualitative data, my intent was to explore the relationship between recovery and social support, in regard to individuals living with an SPMI. As well, I hope to identify a definition of social support, from the perspectives of individuals living with an SPMI, offering a potentially valuable contribution to the literature, given that such a definition is presently absent.

Framework: Personal and Theoretical

Strengths-based Perspective

My personal practice framework is guided by the strengths-based perspective, which Saleebey (1996) suggests:

> ...demands a different way of looking at individuals, families, and communities. All must be seen in the lights of their capacities, talents, competencies, possibilities, visions,

values, and hopes, however dashed and distorted these may have become through circumstance, oppression, and trauma. The strengths approach requires an accounting of what people know and what they can do, however inchoate that may sometimes seem. It requires composing a roster of resources existing within and around the individual, family, or community (p. 297).

Employing a strengths-based approach while serving individuals living with an SPMI has been suggested as a fundamental technique in social work practice (Heinonen & Spearman, 2006). There are many aspects to a strengths-based approach, making it a non-unified perspective, as it is a potpourri of different ideas, notions, and concepts (Heinonen & Spearman). However, a strengths-based approach ultimately draws on individuals' assets and resources, to assist them to, "grow as a human being; improve their quality of life; develop their own problem-solving skills; and deal with their stress and adversity" (Heinonen & Spearman, p. 217).

While working with adults living with an SPMI, I think it is of utmost importance to focus on one's possibilities, capacities, and abilities, as these individuals are oppressed and stigmatized because of their mental illness, often living in abject poverty, and viewed by a deficit or disability lens. The outcome can often look bleak. However, by looking for opportunities and solutions, instead of problems, I believe there is hope and possibility for all people. In taking this approach, Saleebey (1996) suggests, "it takes courage and diligence on the part of social workers to regard professional work through this different lens. Such a 're-vision' demands that they suspend initial disbelief in clients" (p. 297).

The strengths-based approach has been compared to other social work perspectives or approaches. It has been likened to a problem-solving approach, but there are some major differences between the two, as a problem-solving approach focuses on restoration and deficits (Heinonen & Spearman, 2006). While working with individuals living with an SPMI,

the focus is not on restoration, but rather recovery. The suggestion has also been made that a strengths-based approach is compatible with the ecosystem perspective. The ecosystem perspective argues that people, and their environment, should be viewed as a unitary system, mindful of the context in which they are occurring (Gitterman, 1996). Onken, Craig, Ridgway, Ralph, and Cook (2007) support this argument, and link it to supporting individuals on their recovery journeys: "The dynamic interaction among characteristics of the individual (such as hope), characteristics of the environment (such as opportunities), and characteristics of the exchange between the individual and the environment (such as choice), can promote or hinder recovery" (p. 10).

Given that the focus of my practice has been adults living with an SPMI, it was reassuring to discover that Saleebey (1996) confirms my personal practice framework in that he has suggested the use of a strengths-based approach with individuals living with an SPMI has been well documented. Sadly, Borg (2007) points out that psychiatry has historically been based on a medical model, focused on people's deficits, and traditionally has not portrayed hope for people diagnosed with schizophrenia, or any other persistent mental illnesses. Rather, mental illness was seen as incurable, and ultimately a case of steady deterioration (Anthony, 2000). For me, this is why it is so important to approach my practice from a strengths-based perspective, as the concept of recovery resonates within me.

One important aspect of a strengths-based approach is the source of information; the individual who is describing his or her concerns. The person's concern or interpretation of that concern belongs to that person, in that the story is to be accepted as his or her truth. This approach rings true from a social constructivism perspective, which holds that reality is constructed by people (Patton, 2002). For the purpose of this research, I am having

participants construct an idea about the relationship between recovery and social support, as well as develop a definition of social support, based on this population's reality.

The strengths-based approach has encountered some criticism. Saleebey (1996) points out the criticisms, including: "It is just positive thinking in another guise; it simply reframes deficits and misery; and is 'Pollyannaish', or ignores or downplays real problems" (p. 302). Despite the criticism, I believe that the strengths-based approach is the most respectful and appropriate approach for me to serve individuals experiencing an SPMI.

Social Constructivism

The ultimate intent of my thesis is for participants to construct a perspective of how recovery and social support are linked, and a secondary objective is for a participant-identified definition of social support to be developed. This perspective of the linkage between the two concepts is based on the realities of individuals living with serious and persistent mental illnesses. According to Patton (2002), "constructivists study the multiple realities constructed by people and the implications of those constructions for their lives and interactions with others" (p. 96). Not to be overlooked is that "constructivism...points out the unique experience of each of us" (Crotty, 1998, as cited in Patton, p. 97). Therefore, because reality can be different for everyone, it is my intent to try to capture an accurate representation of ideas of how recovery and social support are linked through the words of individuals living with an SPMI. It is recognized that there are multiple perspectives, and therefore definitions, but a representation of ideas is sought.

Patton (2002) suggests one gives thought to several foundational questions when endeavoring along a social constructivism path: "How have the people in this setting constructed reality? What are their reported perceptions, 'truths', explanations, beliefs, and

worldview? What are the consequences of their constructions for their behaviors and for those with whom they interact?" (p. 96). In regard to adults living with an SPMI, I believe that their worldviews may at times be completely different from mine, in that I have not experienced an SPMI, nor have I faced the related societal consequences of oppression, stigma, or poverty.

Creswell (1998) also suggests we ask the question, 'What is the nature of reality?' since social constructivism is based on the idea of ontological relativity. The characteristics and implications of ontological relativity are that individuals construct reality, so therefore multiple realities exist (Creswell). This is construed by using themes and subsequently direct quotes to support the themes, which is evidence of the multiple realities of the same phenomenon (Creswell). By using qualitative inquiry in my thesis research, participants were given the opportunity to share personal stories of their realities. And although each participant was discussing the same topic, the points of view and experiences, at times, were very diverse.

Charmaz (2006) asserts that social constructivists study how people construct meanings. It is important to note that reality is not being constructed; rather knowledge about the reality is being constructed. Charmaz cautions that constructivists should acknowledge that their findings and interpretations of the phenomenon are also a construction.

Reflexivity

The use of reflexivity has been incorporated into my thesis, which is a way of acknowledging self-awareness, including personal biases, assumptions, beliefs, and perspectives (Patton, 2002). Reflexivity, as described by Patton, has "entered the qualitative lexicon as a way of emphasizing the importance of self-awareness, political/cultural

consciousness and ownership of one's perspective" (p. 64). Additionally, reflexivity "reminds the qualitative inquirer to be attentive to and conscious of the cultural, political, social, linguistic and ideological origins of one's own perspective and voice as well as the perspective and voices of those on interviews and those whom one reports" (Patton, p. 64). By being reflexive, I am being true to the research and the participants, as well as myself, exploring any concerns that arise.

My 10 years of experience in the mental health field led me to choose my topic of research. Therefore, I bring with me my assumptions, beliefs, and framework. And because I have a history of working with the individuals who graciously agreed to be my research participants, I was acutely aware of the very real potential of dilemmas occurring between my researcher self and my CMHA supervisor self. According to Woods (2003), I am an 'insider' to the research. Being an insider can sometimes create internal tension trying to separate roles, and can even cause those roles to blur. The use of reflexivity can help sort through some of these emotional issues. Pellatt (2003) agrees and suggests that being reflexive can have an emotional impact on the researcher. At times, it was difficult for me to separate my roles, like when I wanted to assist people who disclosed they were having difficulties and I knew I could assist them in finding the appropriate resource or avenue. Instead, I referred them to other staff who could assist if they wished assistance.

As I worked with research participants and gathered data, I had to be reflexive and examine what I knew and how I knew it. I developed and maintained a research journal, which allowed me to make notes and comments about how the process was evolving for me as I engaged with individuals that I knew from my employment. Patton (2002) suggests that key components of being reflexive include "self questioning and self understanding" (p. 64).

I believe I was highly aware of the potential for blurring roles, and therefore engaged in ample self-examination.

Problem and Objectives

My research will explore the relationship between an individual's recovery journey, in regard to serious and persistent mental illness, and social support. Therefore, the research question is: What is the relationship between recovery and social support for individuals living with a serious and persistent mental illness?

In addition, the following research objectives will be pursued:

1. Inform a qualitative interview guide based upon results from standardized measures for self-reported recovery and social support of individuals living with an SPMI.
2. Explore the relationship between recovery and social support.
3. Identify themes from individuals' personal stories of social support, and identify a definition of social support based on research participants' perspectives.

Conceptualization of Terms

Recovery.

Based on the literature that follows, I conceptualize recovery as the unique personal journey of an individual living with an SPMI. This journey may include learning new patterns of behaviour, coping with living with an SPMI, or changing one's attitudes, goals, skills, or roles. Recovery involves all aspects of a person including the physical, emotional, mental, spiritual, and cultural components. Recovery is not about returning to a 'pre-sick' state, becoming 'cured', or restoring to full functioning. Recovery is a possibility for

everyone, despite acuteness or persistence of symptoms. Recovery is about having a personally satisfying life, despite potential limitations of living with an SPMI.

Social support.

Based on the literature that follows, I conceptualize social support as the perceived feeling of having a person (a spouse, friend, family member, neighbor, clergy, or paid service provider, etc.) available for the following five types of support: emotional; instrumental/tangible; informational; affectionate; and positive social interaction. Emotional support includes such provisions as care, empathy, love, or trust. Instrumental/tangible support is concrete assistance such as tangible goods, services, or aids, including money, food, tobacco, or transportation. Informational support is provided during times of stress or to assist one to problem-solve. Affectionate support is physical support, love or expressions of affection, such as a hug. Positive social interaction includes having someone with whom the person can spend time. Additionally, social support is about having a feeling of belonging and being accepted, without the social support necessarily having to be mutual or reciprocated.

Serious and persistent mental illness.

The phrase serious and persistent mental illness is conceptualized by using the Diagnostic and Statistical Manual of Mental Disorders IV-TR (DSM IV-TR) (American Psychiatric Association, 2000). An SPMI falls within Axis 1 diagnoses, which are clinical disorders, including major mental disorders, such as schizophrenia, mood disorders, or other psychotic disorders. To further conceptualize SPMI, the individual must have a significant functional disability as a result of living with the illness. Significant functional disability is defined as having two or more hospitalizations in the past three years or self-reported

interference with housing, employment or social support, due to living with an SPMI (Anthony, 1993). Disability can be further defined as any restriction or lack of ability to perform a role within the range considered normal for a human being (Anthony). The World Health Organization (WHO) (2002) offers a more current definition of functional disability through the International Classification of Functioning, Disability, and Health (ICF), which involves three levels of human functioning: body or body part; whole person; or whole person in a social context. Dysfunction is when one or more of these levels experiences impairment, activity limitations, or participation restrictions (WHO). Therefore, dysfunction is when there is a significant deviation or loss; difficulty with activities; or difficulty with involvement in life situations (WHO).

Chapter Two: Considering the Literature

In order to understand the context in which recovery and social support occur within community mental health, a review of the literature is necessary. The subsequent literature review will broadly examine the definitions of mental health and mental illness, as well as discuss the use of language when working within the mental health field. Stigma and discrimination will also be addressed, as these can be directly related to the language that we use. Aspects of the historical treatment of individuals living with an SPMI will be reviewed, such as institutionalization, as well as deinstitutionalization, which was the movement of individuals back into the community. The remainder of the literature review will discuss the two broad concepts of recovery and social support.

Mental Health versus Mental Illness

Although much of the literature utilizes the terms mental health and mental illness interchangeably, there are marked differences between the two. To try to define mental health and mental illness, one should not think of the terms as polar opposites. The United States (US) Surgeon General (1999) instead suggests that mental health and mental illness should be thought of as points on a continuum.

The WHO (n.d.) suggests the definition of mental health is broader than a lack of a mental disorder, and is not merely the absence of disease or infirmity. Rather, health is a state of complete physical, mental, and social well-being (WHO). According to Kirby and Keon (2004), mental health refers to various capacities, including:

> ...the ability to understand oneself and one's life, relate to other people and respond to one's environment, experience pleasure and enjoyment, handle stress and withstand discomfort, evaluate challenges and problems, pursue goals and interests, explore choices, and make decisions (p. 67).

Ultimately, mental health is indispensable to personal well-being, family, and

interpersonal relationships, as well as for making a contribution to one's community or society as a whole (US Surgeon General, 1999).

While defining the term mental illness, there is room to discern between mental health concern/problem and mental illness. The major difference between the two terms is that a mental health concern/problem does not display the intensity nor duration needed to meet the criteria for a mental illness as suggested by DSM IV-TR (American Psychiatric Association, 2000). Kirby and Keon (2004) add that a mental health concern/problem refers to a variety of diminished capacities, including cognitive, emotional, attentional, interpersonal, motivational, or behavioral capacities. This diminished capacity adversely affects and/or interferes with people's enjoyment of life, or negatively affects their interactions within their environment or society. Kirby and Keon continue to define mental health problems as being relatively short in time to resolve, non-reoccurring, and causing non-significant disability.

Mental illness is a health condition that is described by alterations in thinking, mood, or behavior, or some combination thereof (Substance Abuse and Mental Health Services Administration, n.d.), and is associated with distress and/or impaired functioning (Health Canada, n.d.). Mental illness, as defined by Kirby and Keon (2004):

> ...generally refers to clinically significant patterns of behavioral or emotional function that are associated with some level of distress, suffering (even to the point of pain and death), or impairment in one or more functional areas (e.g., school, work, social and family interactions) (p. 68).

Kirby and Keon sum up the discussion about mental health and mental illness by stating: "Mental illness undermines mental health, but mental health is more than simply the absence of illness. It is a fundamental resource of all human beings and an essential component of all health" (p. 67). People who live with a mental illness can be mentally healthy, in that the

illness creates only a limited impact on their lives. Therefore, clarification and distinction between the two terms is necessary.

Language

There really is no commonly accepted language or terminology used to describe the concepts and matters in the area of mental illness. This is because there is little agreement with regards to which language is the most respectful to identify individuals who have experienced a mental illness (US Surgeon General, 1999). The terms used to describe a person with a mental health problem or an SPMI have changed over the years. When subscribing to the medical model for treatment, the person is usually referred to as a 'patient' (Anthony, 1993). This language is used even when a person is living in the community. As the treatment model shifts to more community-based services, the terms have changed to 'client' or 'service user' (Anthony, Cohen, & Farkas, 1990). The psychiatric rehabilitation model of treatment uses the language of 'consumer' (Anthony et al.), where the recovery-oriented model suggests that a person should simply be referred to a 'person' or 'individual' (Jacobson & Greenley, 2001). Some individuals have chosen to use the term 'psychiatric survivor'; a term felt to acknowledge the personal strength required to cope with an SPMI, as well as the mental health system (Psychiatric Survivor Archives of Toronto, n.d.; Psychiatric Survivors of Ottawa, n.d.). Throughout this paper, I will refer to people living with an SPMI as a 'person' or 'individual', as suggested by the recovery-oriented services model.

Stigma and Discrimination

Some people have very strong feelings about the language used in view of the societal stigmatization and pejorative labeling that is commonly encountered by individuals living with an SPMI (US Surgeon General, 1999). Stigma, as defined by Link and Phelan (2001)

exists "when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them" (p. 377). On a regular basis, people living with a mental illness face stigma and discrimination by being labeled, which maintains stigma and dehumanizes the individual living with the illness. The Canadian Mental Health Commission (n.d.) denotes a difference between stigma and discrimination, in that stigma is an attitude, and discrimination is the action or behavior that results from stigma. According to the Canadian Medical Association's (2008) eighth annual National Report Card on Health Care in Canada, Canadians in general have harsh attitudes towards individuals with mental health problems. A sample of the statistics found that one in four Canadians are fearful of being around a person with a mental illness, and only half of Canadians would tell a friend or a coworker that they have a family member with a mental illness. Meanwhile, the majority of Canadians would not hire someone with a mental illness. The president of the Canadian Medical Association summarizes the statistics by stating "In some ways, mental illness is the final frontier of socially-acceptable discrimination" (p. 1).

Individuals sometimes lose themselves to the mental illness, in that they become 'the bipolar' or 'the schizophrenic', rather than a person living with the particular illness. As well, not long ago, people living with an SPMI would be referred to as chronically ill. Capponi (2003) argues that when someone with a mental illness is referred to as 'chronic', it is simply a label that describes the care that he or she receives. Language is an instrument used to keep stigma in place as "most of us use terms and expressions related to mental illness that may perpetuate stigma" (Mental Health Education Resource Center of Manitoba, n.d.). Capponi (2003) argues "the sense of self disappears as we seem to become the physical manifestation of mental illness" (p. 110). Being mindful of the language that I use, which includes avoiding

the use of labels, referring to people as people, and not using terms or expressions related to mental illness, such as 'crazy', are important to me and inform my personal practice.

Institutionalization

The history of institutionalization began with the use of almshouses, dating back to about the eighteenth century, for any person thought to be poor, orphaned, maimed, or mentally ill (Sussman, 1998). The primary purpose of almshouses was confinement so that the larger societal population was protected (Carling, 1995; Rothman, 1990; Simmons, 1990). In the nineteenth century, the mentally ill were moved from almshouses into asylums or institutions, leaving behind the poor, the orphaned, and the maimed. Sussman argues "the process of institutionalization began with humane intentions as part of a progressive and reformist movement, which attempted to overcome neglect and suffering in the community, jails, poorhouses, and 'hospitals'" (p. 262). However, the physical structures used for the institutions were generally disgraceful, dirty, and overcrowded (Rothman).

Treatment for the mentally ill was almost nonexistent in the institutions, as it was believed that mental illness was incurable; a case of steady deterioration (Anthony, 2000). Therefore, treatment consisted of confinement from society and physical restraint up until approximately the 1940s (Fennell, 1996). During the 1940s and 1950s, experimental 'therapy' was used to treat the mentally ill, including psychosurgery (lobotomy), insulin coma therapy, and shock therapy (electro-convulsive therapy) (Fennell). Shortly after the implementation of the various therapies, during the 1950s, psychotropic medication started to be used. The primary treatment choice then shifted to chemical restraint (Carling, 1995). Although psychotropic medication controlled psychiatric symptoms, and later aided in the return of individuals back to society (deinstitutionalization), the drugs caused serious side

effects, including rigidity of the body, tardive dyskinesia (involuntary, repetitive movements), or even death. Psychotropic medications are still a primary method of treatment today, and people continue to experience side effects. However, there are measures in place to monitor drug levels, as well as additional medications to reduce the side effects.

Deinstitutionalization

In the 1960s, people who were institutionalized began to be moved back into the community, a practice termed deinstitutionalization. This shift was based on the belief that all individuals have the right to live in their community of choice, with the hope of achieving autonomy, choice, freedom, dignity, and respect (Schneider, 2000). However, Capponi (2003) says that deinstitutionalization was motivated more by economic considerations than by a liberal view that antipsychotic medication made it possible for people to return to their communities. Capponi was probably accurate, given the rapid movement of 'mental health patients' out of hospitals and into the community despite the comparatively slow growth of necessary community-based mental health services (Sealy & Whitehead, 2004).

Upon being moved into the community, people living with an SPMI were locked in a system that was based on a principle that people did not recover. Instead it was believed that mental illness was a case of deterioration, or at best, maintenance (Anthony, 2000), and beyond the control of the individual (Borkin, 2000). Around this time, the civil rights movement began to advocate for the rights of all individuals to have full citizenship in their communities (Bond, Salyers, Rollins, Rapp, & Zipple, 2004). This led to a new era for individuals living with an SPMI, including 'measures of success'. Nelson, Lord, and Ochocka (2001) offer the following statement regarding 'success':

> In the traditional paradigm, studies of the effectiveness of different treatment and rehabilitation programs have used measures of hospitalization and reduction in

> symptomology as outcome indicators. By these criteria, a person with a serious mental illness who lives an isolated existence in run down housing; who performs monotonous tasks in a sheltered workshop for little or no pay; and who is asymptomatic can be considered a 'success' (p. 33).

This quote identifies the reality of the mental health system. If a person living with an SPMI is residing in the community, seemingly has activity, and presents 'well' mentally, then success has been achieved. Unfortunately, what this approach to 'success' fails to address is the issue of quality of life.

Recovery

The concept of recovery emerged around the 1980s, in conjunction with deinstitutionalization as individuals living with a mental illness began sharing and publishing their personal accounts of recovering (Andresen, Oades, & Caputi, 2003). Although the term recovery has only been used in the past couple of decades, people have been recovering for much longer. Both individuals living with a mental illness and service providers have described recovery. However, Andresen and colleagues argue that recovery should only be conceptualized by individuals who have actually experienced recovery.

What are People Recovering From?

When asked the question 'What are people recovering from?' the answer is complex. After engaging in extensive reading on the topic of recovery, and reflecting on the literature, my frame of recovery expanded to become inclusive of many aspects. Recovery is from a host of different concerns; the actual mental illness in only one area. There are at least three other areas of recovery, including:

1. Loss, which may include family, relationships, friendships, home, job, self, hope, goals, or dreams.
2. Stigma, both internal and societal.

3. The mental health system.

Personal stories and journeys have revealed the painful truth that people have lost homes, careers, relationships, friendships, children, hopes, and dreams when mental illness presented, or symptoms were exacerbated (CMHA BC Division, 2002; Mosoff, 1997; Schiff, 2004). However, these losses are not due to something being 'wrong' with the person, but rather how people are treated by both the mental health system and society as a whole (Tooth, Kalyanasundaram, Glover, & Momenzadah, 2003). The concept of recovery is complex, thus when defining recovery, multiple facets should be considered, as "using a narrow definition of recovery apparently yields only a narrow lens of the person's overall functioning" (Davidson, Lawless, & Leary, 2005a, p. 665).

Leete (1989) and Deegan (2001) argue that overcoming internal stigma is a crucial first step towards recovery. One must look inside oneself and identify strengths, reject internalized stigma, and learn not to be ashamed. Societal stigma is also present, as people have preconceived ideas and notions about people living with an SPMI, such as their limited abilities for work, education, family, or relationships. Capponi (2003) asserts that stigma is sometimes worse than the illness itself. Ultimately, recovery is not solely from mental illness. Rather, "people experience themselves as recovering a new sense of self and purpose within and beyond the limits of disability" (Deegan, 1988, p. 12).

Recovery Described

According to the literature, the term recovery has been described many different ways. Anthony (2000) has developed a definition of recovery in consultation with individuals living with a mental illness:

> A deeply personal, unique process of changing ones' attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life

> even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (p. 159).

Kerkser (n.d.), as cited in Henderson (2004), adds:

> ...recovery is the development of new ego and identity structures to replace those damaged by our illnesses. Recovery is about wellness, that is, the redevelopment of a new and healthier personality and lifestyle, an independent personality that is strong enough to stand on its own. Recovery takes place through creation of new patterns of behavior that make our lives more satisfying and productive (p. 83).

In addition to operationalizing recovery, it is important to note that recovery does not necessarily imply full recovery (Anthony, 2000). As well, recovery does not solely focus on symptom relief (Anthony, 1993). Instead, recovery is about living with the illness, which may include being involved with mental health services, pharmacological treatment, skills training, or psychological and social support for individuals and families to improve lives and functional capacities. The point is that recovery does not refer to any specific services, as it is the lived experience of gaining a new and valued sense of self and purpose as the individual chooses (Deegan, 1988).

Internal and External Conditions

Jacobson and Greenley (2001) suggest the process of recovery requires a certain combination of conditions, both internal and external. The internal or personal conditions are hope, healing, empowerment, and connection. The external conditions that facilitate recovery are implementation of the principle of human rights; a positive culture of healing; and recovery-oriented services.

Hope contributes to recovery in that the individual believes that recovery is possible. Hope is the emotional essence of recovery because it is a "promise that things can and do change, that today is not the way it will always be" (Jacobson & Curtis, 2000, p. 335). The

attitudinal components of hope include recognizing and accepting that there is a problem, committing to change, focusing on strengths, looking forward to the future, celebrating small successes, reordering priorities, and being optimistic (Jacobson & Greenley, 2001). Weick (1984) offers the 'small wins theory' that speaks to celebrating small wins and acknowledging that change does not happen at once; rather change is the result of a series of small successes. Hope lays the groundwork for recovery because hope sustains; coloring every perception and remaining positive even during relapse (Jacobson & Greenley).

Healing can be divided into two components: defining self (apart from illness) and control (Jacobson & Greenley, 2001). Healing is different for everyone, and the end result is different for each individual. As people reclaim themselves and reconceptualize their illness, a sense of self-esteem and self-respect is achieved (Jacobson & Greenley; Pierce, 2004). This allows one to challenge the stigma and perception that an illness defines a person. Defining self can be realized by the individuals themselves, or through assistance and teaching from peers, support people, or service providers. Gaining a sense of control over the illness is also a key component of healing. This can be achieved by finding and using strategies to relieve symptoms of the illness or reducing the social and psychological effects of stress, through the use of medication or self-care practices (Chamberlin, 1998; Deegan, 2001). Another aspect of control is looking at who is in control, termed locus of control. When addressing recovery, it is the individual who is taking control of his or her own life, and the service providers are on the periphery (Andresen et al., 2003; Hatfield, 1994). However, this can become problematic when the service provider disengages from service on the assumption that the individual is no longer in need of assistance, or if a service provider does not believe in recovery.

Empowerment is sometimes the result, or the corrective, from years of lack of control, including helplessness and dependency, which an individual may have experienced from being in the mental health system (Jacobson & Greenley, 2001). Empowerment emerges from inside a person, although empowerment may be facilitated by external conditions (Nelson et al., 2001). There are three components to empowerment: autonomy, courage, and responsibility (Jacobson & Greenley). Autonomy is the ability to act as an independent agent, made possible when an individual is knowledgeable, has self-confidence, and has meaningful choices available. Courage is important because it allows an individual to take risks, express his or her own voice, and step outside safe routines. Responsibility relates to the individual's obligations. It is acknowledged that individuals should identify factors that are empowering to them (Nelson et al.). People living with an SPMI have defined empowerment in the following terms: self-determination, decision-making, independence, voice, assertiveness, self-understanding, and self-esteem (Nelson et al.).

Connection is the fourth and final internal condition required for recovery, and is important because recovery is a profoundly social process (Jacobson & Greenley, 2001). Bond et al. (2004) believe that connection contributes to the recovery process for two reasons: it allows for pursuit of personal goals, self-efficacy, and self-determination; and leads to greater self-confidence and hopefulness. Connection has to do with rejoining the social world, something that is often lost, or taken away, when an individual is ill. "The ability to forge connections with others is both a result of hope, healing, and empowerment and a way to make these internal conditions possible" (Jacobson & Greenley, p. 485).

Connection involves integration and discovery of roles to play in the world, such as engaging in recreational activities, forming relationships, or gaining an occupation with the

end goal being to find belonging in a 'community'. Bond et al. (2004) define community integration as being *of* a community and not just physically located *in* the community. This entails helping individuals to move out of patient roles, sheltered workshops, or institutions, and shift towards independence, including engagement in roles within the community such as employment, social recreation, volunteerism, education, or independent living. Connection with a community can ultimately act as the bridge between internal and external conditions (Jacobson & Greenley, 2001).

The external conditions that define recovery, as previously mentioned, are: implementation of the principle of human rights; a positive culture of healing; and recovery-oriented services. "On the surface, the first three conditions seem quite different, as human rights denotes a broad, societal condition; a positive culture of healing refers to the cultural milieu in which services are offered; and recovery-oriented services are the actual services provided" (Jacobson & Greenley, 2001, p. 483). As these conditions are viewed through the same lens, one can see that "implementation of the principles of human rights in an organization results in a positive culture of healing and recovery-oriented services are services that emerge from such a culture" (Jacobson & Greenley, p. 483). Service providers should be informed about recovery and mindful of practice, as well as aware of the culture portrayed via community mental health services.

Human rights advocates seek equitable distribution of power and resources. In regard to people living with an SPMI, discrimination and stigma present challenges, as does attempting to navigate the service system. Individuals should have equal opportunities for education and employment, as well as have the fundamental necessities such as adequate food and housing (Chamberlin, 1998; Jacobson & Greenley, 2001). Additionally, individuals

should have access to social and health services that can aid in recovery, including access to medical and dental treatment, mental health services, job training, supported housing, lifeskills support, and vocational training programs. Advocates can lend their voice to ensure concerns are heard and assist individuals with their specific needs.

A positive culture of healing includes having both service providers and individuals receiving services empowered and engaged (Jacobson & Greenley, 2001). Empowered service providers believe they can make a difference, but also embrace the belief that every individual can achieve hope, healing, empowerment, and connection, regardless of current status. Further to this is a strength-based, person-centered, goal-directed approach. The focus should be on a person's strengths and abilities, rather than their challenges or disabilities. As well, it is the person that is receiving the service, not the disability; for example, 'the schizophrenic'. Focus should be on attainable goals. Collaboration is also important, in that the person and service provider work together, instead of the service provider dictating the service (Andresen et al., 2003; Hatfield, 1994). Collaboration allows the individual to take an active role and have the service provider act as a facilitator of services. The positive culture of healing leads to recovery-oriented services. It is important to note that "no service is recovery oriented unless it incorporates the attitude that recovery is possible and has the goal of promoting hope, healing, empowerment, and connection" (Jacobson & Greenley, p. 484).

Assumptions

Anthony (2000) lists seven assumptions about recovery. The first is recovery can occur without service provider intervention, as service providers do not hold the answer to recovery; rather, individuals do. The role of the service provider then is to facilitate recovery for the individual while the role of the individual is to recover. The second assumption is the

benefit of the presence of people who believe in, and stand by, the person in need of recovery. It has been identified that recovery requires at least one person who can be trusted and 'be there' in times of need. The third assumption is that a recovery vision is not a function of one's theory about the cause of mental illness, as recovery may occur whether one's beliefs about onset of mental illness are biological or not. The fourth assumption is that recovery can occur despite acute exacerbations of symptoms. The reality is that while serious mental illness is episodic in nature, it does not prevent recovery, as symptoms interfere with functioning less often and less intensely when recovering. The fifth point is that recovery is a unique, highly personal, and individual process; there is no one path, nor one outcome. The sixth assumption is that recovery demands that a person has choices. It is vital to offer a selection of options for the individual to choose from, rather than provide only one 'choice'. The final assumption is that recovering from the illness itself is easier than recovering from the consequences of living with the illness, as a person living with mental illness may experience discrimination, poverty, segregation, and stigma.

Psychiatric Survivor Versus Service Provider

People living with a mental illness, termed psychiatric survivors, along with service providers, have made contributions to the recovery literature (Jacobsen & Curtis, 2000). There is overlap between the two perspectives, with some service providers and academics also identifying themselves as living with a mental illness. The two perspectives include both overlap and divergence. For example, psychiatric survivors argue against the idea that a person must return to their pre-illness state (Deegan, 2001; Hatfield, 1994). Kersker (n.d.), as cited in Henderson (2004), adds that "The idea that we can be 'cured' is counterproductive to recovery..." (p. 83). Anthony (2000), an academic, suggests, recovery is a unique and

personal journey, so to focus on a cure, lessening of symptoms, reduction of hospitalizations, or improvement in functioning, is neither assessing nor achieving recovery.

There have been instances when individuals living with an SPMI become disempowered when a service provider presents the idea of knowing what is best for the individual (Andresen et al., 2003; Hatfield, 1994). Sometimes, service providers claim to offer recovery-oriented services, but instead are "simply repackaging old wine in the new bottle of recovery language" (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005b, p. 481). Schiff (2004) argues, "the recovery movement belongs to consumer-survivors, not to practitioners" (p. 212).

Social Support

The concept of social support is quite broad, thus it requires clarification in relation to its use in this thesis research. The following literature review on social support will distinguish between the two concepts of social support and social network, examine the attributes of social support, explore the perception versus experience of social support, as well as review pertinent social support theories.

Social Support Versus Social Network

The terms social support and social network are sometimes used interchangeably, but are indeed very different (Hutchinson, 1999; Stewart, 1993; Sullivan & Poertner, 1989). It has been suggested that when designing a study to measure social support, a very clear definition has to be conceptualized, and a distinction made between social support and social network (Hutchinson). Criticism of the literature on social support suggests that most definitions have been poor, in that some are circular, overly inclusive, and lack explication,

theoretical grounding, and conceptual clarity (Hutchinson; Stewart). For a definition to offer clarity, the type, source, and outcome of social support should be described (Stewart).

Social support has been defined by Shumaker and Bronwell (1984) as "the exchange of resources between at least two individuals that is perceived by the provider of the recipient to be intended to enhance the well being of the recipient" (p. 13). Moss (1963) adds that subjectivity is important when defining social support: "a subjective feeling of belonging, of being accepted, of being loved, of being needed, all for oneself and not for what one can do" (as cited in Langford, Bowsher, Maloney, & Lillis, 1997, p. 96). The distinction between social support and social network is that social support acknowledges the perception and subjectivity of support, whereas a network is where the feelings of support originate.

There are several considerations when defining social network. Beyond a simple definition of social network are the characteristics of a network and the relationship social support has with a social network. Walker, MacBride, and Vachon (1977) offer the following definition of social network:

> A set of personal contact through which the individual maintains his social identity and receives emotional support, material aid and service, information and new social contacts...this network may include relatives, friends, neighbors, fellow employees, or professionals paid for their services (p. 714).

Bradshaw and Haddock (1998) postulate that networks have two sets of characteristics: structural and functional. Structural characteristics refer to the size (number of members) and density (extent of contact with members), whereas functional characteristics refer to the quality of relationships among the network members. Langford et al. (1997) offer this linkage between social support and social network: "Without a structure of people (network) with the quality of connectedness (embeddedness) required to generate an atmosphere of helpfulness and protection (social climate), social supportive behavior cannot occur" (p. 97).

Although social support is positive, offering many health benefits, social networks can also be a source of stress (Stewart, 1993).

Perceived Support Versus Experienced Support

The literature has highlighted the need to distinguish between perceived social support and experienced social support, as there is a difference between support that is available and support that is perceived to be available (Hutchinson, 1999). Perceived support is the person's perception of support, and will translate into who or what that person identifies as support to him or her. Experienced support is the actual number of people who support that person, as identified by the person. It is argued that what is most important is the perceived satisfaction of the social support (Clinton et al., 1998; Sullivan & Poertner, 1989).

Attributes

Langford et al. (1997) suggest that there are four defining attributes of social support: emotional, instrumental, informational, and appraisal. Hays, Sherbourne, and Mazel (1995) suggest that emotional and informational supports are the same, as well as instrumental and tangible supports. Additionally, Hays et al. include affectionate support and positive social interaction within their four types of support. Emotional support includes such provisions as care, empathy, love, or trust, and is suggested to be the most important for the perception of conveyed support. Instrumental support is concrete assistance, such as the provision of tangible goods, services, or aids. Informational support is provided during times of stress or to assist one to problem-solve. Appraisal support involves the communication of information that is in reference to self-evaluation, which assists in affirming the appropriateness of the support, either the instrumental tangible act or informational statement. Affectionate support

is physical support, such as a hug, or an expression of love or affection. Positive social interaction includes having someone with whom to spend time.

Reciprocity

In addition to the attributes of social support, it is suggested that exchange or reciprocity must be present for the support to continue (Langford et al., 1997). However, there is controversy in the literature about individuals living with an SPMI, in that it is suggested that social support does not need to be mutual or reciprocated, but rather the most important aspect of support is whether a person perceives that he or she is supported (Clinton et al., 1998; Sullivan & Poertner, 1989).

Theories

A criticism of current definitions of social support is that they lack theoretical grounding (Hutchinson, 1999). Various theoretical foundations have been proposed in the literature (Cohen & Willis, 1985; Langford et al., 1997). Langford et al. highlighted the following three theories: social comparison, social exchange, and social competence, where Cohen and Willis proposed the buffer theory.

Social comparison theory suggests that people develop their own self-concept using comparison between themselves and others in their chosen reference groups, which is important for the development of self-concept, coping abilities, emotional adjustment, self-esteem, and psychological well-being (Swann & Brown, 1990).

The premise of social exchange theory is that human behavior is the exchange of mutually rewarding activities in which the receipt of rewards is contingent on favors returned (Tilden & Gaylen, 1987). Therefore, as people engage in social support, mutuality develops as people are rewarded with the positive mutual effects.

Social competence is described as the ability to interact effectively with the environment, and is essential to the formation and maintenance of relationships (Stewart, 1993). However, people may still perceive support even though their relationships are seemingly unformed or un-maintained.

The final theory to be discussed with respect to social support is the buffer theory (Cohen & Willis, 1985). The buffer theory suggests that social support buffers or protects a person from the potentially harmful influence of stressful and unpleasant events (Rogers et al., 2004). Generally, the role that social support plays is to act as a mediating force between the person and life's occurrences, whether positive or negative, in one of two ways: either intervening between the stressful event or the stress reaction, or by reducing the stress reaction (Cohen & Willis).

Social Support and SPMI

Three theoretical models have been developed to explain the relationship between social support and people living with a serious and persistent mental illness (Calsyn & Winter, 2002). The first is the social causation model, which suggests that lack of social support causes psychiatric symptoms. The second is the social selection model, which suggests that psychiatric symptoms cause changes in social support. For example, driving others away or misperceiving social attempts by others. The third is the reciprocal effects model, which suggests that the relationship between social support and psychiatric symptoms is reciprocal. The lack of social support for a person living with an SPMI exacerbates psychiatric symptoms. This exacerbation makes it harder to form relationships due to both positive and negative symptoms. Positive symptoms may include paranoia, delusions, hallucinations, or bizarre behavior, all of which can make other people feel uncomfortable,

further complicating the process of forming relationships. Negative symptoms may include lack of motivation or withdrawal from others. As a person becomes more isolated, the psychiatric symptoms continue to exacerbate, and the reciprocity continues.

Social support provided by the members of a person's social network could act as a mediating agent for life's stressful or disappointing events (Sullivan & Poertner, 1989). Ultimately, social support is crucial for many different reasons.

Recovery and Social Support

A link between recovery and social support is offered by Anthony (2000), as he describes the role of social support for individuals on their recovery journey, asserting that the common factor in recovery is the presence of people who believe in and stand by the person: "...people who believed in them when they did not believe in themselves, who encouraged their recovery but did not force it, who tried to listen and understand when nothing seemed to be making sense" (p. 161). Bond et al. (2004) suggest that deinstitutionalization for some people has had a negative impact, as "among those consumers counted as 'living in the community' are many who are leading lonely, isolated, barren lives, often without social or recreational outlets" (p. 573). Simply put, like anyone else, people living with an SPMI want more than just symptom relief; they want a host of needs met, including social needs and a sense of connection (Anthony, 1993). Capponi (2003) agrees, stating there are three basic needs: a home, a job, and a friend.

The literature cites many studies on the relationship between the broad concepts of social support and mental illness. Rogers et al. (2004) have found that social support is predictive of fewer psychiatric symptoms and people with larger, more supportive social networks are admitted to hospital less frequently (Clinton et al., 1998). However, research

also suggests that people living with a mental illness have smaller and/or less satisfactory support networks (Bradshaw & Haddock, 1998; Corrigan & Phelan, 2004; Pernice-Duca, 2005; Sullivan & Poertner, 1989). Bradshaw and Haddock propose that the overall social support network shrinks after the onset of a mental illness. This can lead to social networks consisting solely of family members and/or paid service providers. Pernice-Duca established that family members of people living with an SPMI dominated a person's social support network. Stein and Cislo (1994) found that people living with a mental illness have support networks with fewer members, fewer intimate relationships, and perceived their support as being less supportive than people without a mental illness. Corrigan and Phelan suggested that recovery was positively associated with size of the support network. Positive aspects of social support are that social support facilitates coping and competence, and assists people living with an SPMI to remain well in the community and contributes to community adaptation (Clinton et al., 1998; Drake, 2005).

Social support is important for people living with a mental illness to facilitate a sense of connection and community, as loneliness can be a prominent theme. Studies have found that the social networks of people living with a mental illness tend to consist of four to five people, compared to networks of 40 people among the general population (Bradshaw & Haddock, 1998; Pernice-Duca, 2005). As previously mentioned, there are negative symptoms associated with a serious mental illness, including lack of motivation or ability to form and/or maintain relationships, depending on the age when one experiences the onset of the illness (Bradshaw & Haddock). Additionally, individuals may become increasingly withdrawn, leading to the loss of existing relationships (Bradshaw & Haddock). It can be difficult to

maintain or develop relationships with frequent and/or lengthy hospitalizations, or if socialization 'skills' have never been developed.

Baker, Jodrey, and Intagliata (1992) have looked at two specific aspects of social support: availability and adequacy. Satisfaction with life was positively associated with availability of social support. This could be due to the opportunity to engage in social activities or because others provide a reference group for acceptable standards in different life areas (Baker et al.). It was also reported that people living with an SPMI have fewer people dependent upon them for advice, support, and assistance (Baker et al.). This can be detrimental, as other research has found that providing support to others allows for practicing social skills, and also for improved self-esteem and self-worth (Bradshaw & Haddock, 1998).

It has been suggested that people living with an SPMI who improve their social support, as well as those who maintain adequate social support, report that they have greater life satisfaction, which can ultimately lead to improved recovery (Baker et al., 1992). Corrigan et al. (1999) found that recovery was positively associated with the size of the support network. Anthony (1993) presents the link in the following way: "Recovery is a deeply human experience, facilitated by the deeply human responses of others" (p. 160).

In conclusion, the literature defines both recovery and social support, and highlights the importance of social support, while noting the challenges for people living with an SPMI. However, with the limited research examining the recovery process and its relationship with social support, I believe that this study will be of benefit to better understand the relationship between the two concepts. Additionally, there are several articles and definitions of recovery from a consumer's perspective, but the literature about social support seems limited solely to the academic realm. Therefore, another interest is to hear the perspectives of individuals

living with an SPMI about social support, so this important contribution could be added to the literature.

Chapter Three: Research Methodology and Design

This chapter will describe the methodology and design of my thesis research. My exploratory mixed-methods research thesis has sought to explore the relationship between recovery and social support for individuals living with serious and persistent mental illnesses. The quantitative data analysis included chi-squares and was targeted specifically to inform the draft qualitative interview guide. The qualitative data was then analyzed using a thematic analysis. Descriptive statistics and frequencies were run on the demographic data for both the quantitative and qualitative study phases. Issues relating to the credibility and trustworthiness of this study will be discussed, as well as ethical considerations. Please refer to Chapter Four for findings.

Mixed Methods

The quantitative research approach is suited to study measurable and observable facts (Neuman, 2003). Quantitative methods produce numerical data, whereas qualitative research produces non-numeric data, such as words, stories, drawings, or photos. Qualitative research emphasizes depth of understanding and deeper meanings of human experiences, while attempting to generate more theoretically-rich observations (Rubin & Babbie, 2004). Halmi (1996) adds, "qualitative research methods assume that the subjective dimensions of human experience are continuously changing and cannot be studied using the principles of quantitative research methodologies" (p. 364). Sherman and Reid (1994) propose that qualitative research is "better able to take into account contextual factors, detect elusive phenomenon, and generate more thorough descriptions as a base for generalization" (p. 487). Both methodologies are important for knowledge building. Hartman (1994) suggests that the

two approaches are not only compatible, but are complimentary: "the strengths of one tend to be the weaknesses of the other" (p. 487).

An emerging body of literature has critiqued the strategy of combining methods, and has made suggestions on how to successfully design a mixed methods study. Concerns about mixing methodologies have included poor understanding of the particular methodology's theoretical underpinnings and poor analysis/use of the data (Plano Clark, Huddleston-Casas, Churchill, O'Neil Green, & Garrett, 2008; Sale, Lohfeld, & Brazil, 2002). Therefore, there are several considerations when using a mixed methodology, including timing, weighting, and mixing of the methods (Morgan, 1998; Plano Clark et al.).

In regard to timing, it should be determined which method will be employed first (Plano Clark et al., 2008). Morgan (1998) suggests that the researcher should assign one method as the principal tool for gathering the data. The next consideration is the weighting of the data, and how much value will be given to the particular method's findings (Plano Clark et al.). The final consideration is the mixing of the methods, which looks at how the quantitative data and results are mixed with the qualitative data and results (Plano Clark et al.). Morgan asserts that the methods should - "connect different types of information in ways that maximize their contributions to the success of the overall research project" (p. 367).

The quantitative data collection method was used first in this thesis research; scales were completed and analyzed and the findings informed the draft qualitative interview guide. Although the interview guide was informed by the quantitative method, the majority of the findings were derived from the qualitative method. Thus, while this research used a mixed methods approach, the results focused on the qualitative data to answer the research question and meet the accompanying objectives. However, despite the heavy weighting of the

qualitative method, by using a mixed methods approach and verification/checking with interview participants, triangulation was addressed and will be discussed later in this chapter.

Study Process

The process of my study included two phases. The first phase was the collection of the quantitative data. Upon collection, the data was analyzed, and then used to inform the draft qualitative interview guide. Process and description of the quantitative analysis will be discussed later in this chapter. The second phase of the study was the collection of the qualitative data, through one-on-one semi-structured interviews.

Phase One

Recovery Assessment Scale.

The first scale, titled the Recovery Assessment Scale (RAS), measured recovery (Appendix A). The RAS took approximately 10 minutes to complete, although the literature suggested it would take 20 minutes. The RAS contained 41 items, and used a five-point agreement scale (1 = strongly disagree to 5 = strongly agree) (Corrigan et al., 1999). Examples of statements from the scale include: "I have a desire to succeed" and "I can handle it if I get sick again" (Corrigan et al.). The RAS yields acceptable reliability and validity; test-retest reliability of $r = 0.88$ and Cronbach's Alpha $= 0.93$ (Corrigan et al.).

Trying to locate an appropriate, valid measure to quantitatively explore recovery proved to be a challenge. It has been argued that measuring recovery is difficult, due to the unique and diverse experiences of each individual's recovery journey (Allott, Loganathan, & Fulford, 2002) and that the development of instruments to measure recovery is in its infancy (Ralph & Kidder, 2000). However, there is support amongst the recovery literature that the Recovery Assessment Scale (Corrigan et al., 1999) is the most appropriate and valid

quantitative measure of recovery (Andresen, Caputi, & Oades, 2006; McNaught, Caputi, Oades, & Deane, 2007; Pernice-Duca, 2005; Ralph, 2000; Ralph & Kidder).

According to Ralph and Kidder (2000), several scales have been developed to attempt to measure components of the subjective experience of recovery. Of note is the critique that only components of recovery are being measured, rather than the broad spectrum of the experience of recovery. Other quantitative measures have been mentioned in the literature, but have been faced with criticism, including having poor construct validity (Ralph & Kidder) and limited psychometric data (McNaught et al., 2007).

Corrigan, Salzer, Ralph, Sangster, and Keck (2004) subsequently conducted an exploratory factor analysis on the 41-item RAS. The findings produced 22 items divided into five factors. The five factors included: personal confidence and hope; willingness to ask for help; goal and success orientation; reliance on others; and not dominated by symptoms (Corrigan et al.). Cronbach's alpha scores ranged from .74 to .87; which is acceptable validity (Corrigan et al.). However, Andresen et al. (2006) have pointed out that Corrigan et al.'s factor analysis omitted all items that referred to self-management of symptoms, a theme that has been prominent in the recovery literature. Therefore, this thesis research used the 41-item RAS, rather than the 22-item, five-factor version. Thus, the items referring to the self-management of symptoms were not excluded. As well, Dr. Patrick Corrigan assured me that using the 41-item scale would be appropriate for my study (personal communication, February 2, 2009).

To score the RAS, the answers for the 41 items are summed, producing a total score. The highest possible score that can be achieved is 205 and the lowest possible score is 41. According to Corrigan et al. (1999), the total score has been shown to positively associate

with empowerment, coping ability, and quality of life, and inversely associate with psychiatric symptoms.

Social Support Survey Instrument.

To measure social support, the Medical Outcomes Study (MOS) Social Support Survey Instrument was used (Hays et al., 1995) (Appendix B). The scale included 19 items and asked participants how often support is available to them, using a five-point rating scale (1 = none of the time to 5 = all of the time). The support is divided into four sub-types of support, including: emotional/informational support; tangible support; affectionate support; and positive social interaction. Sample items include, "Someone you can count on to listen to you when you need to talk", "Someone to help you if you were confined to bed", "Someone who shows you love and affection", and "Someone to have a good time with". The scale reports good construct validity, and reports reliability as r = 0.90 (Hays et al.).

With regard to selecting an appropriate scale to measure social support with this specific population in mind, I received assistance from Dr. Jill Grant, from the University of Windsor. Dr. Grant has used this particular scale with her own research, and upon researching various scales, found this was the most suitable with regard to the questions it asks, as well as the most straightforward in its style (personal communication, February 3, 2009). It is important to note that the MOS: Social Support Survey Instrument was not developed for any specific population. There does not appear to be a tool available to measure social support for this specific population.

To score the MOS: Social Support Survey Instrument, the average score can be calculated for each of the four sub-scales. Scoring can be done separately for each of the

social support sub-scales, or collectively for the overall functional social support index. The highest possible score that can be achieved is 95 and the lowest possible score is 19. The higher the score for an individual sub-scale, or for the overall support index, the higher level of support indicated (Hays et al., 1995).

With regard to the collection of the quantitative data, along with the two scales, basic demographic information such as age, gender, ethnicity, marital status, employment status, diagnosis, and clubhouse participation was collected for each participant (Appendix C).

Phase Two

Phase two of my study included conducting one-on-one semi-structured interviews. The interview guide was informed and fine-tuned by the quantitative findings. As well, demographic information such as age, gender, ethnicity, marital status, employment status, diagnosis, and clubhouse participation was collected for each participant. Additionally, status with regard to the living arrangements of participants was also collected. The details of the process will be discussed later in this chapter.

Study Participants

Locating the sample.

The sample was accessed through CMHA's Connections Clubhouse. According to the International Center for Clubhouse Development (n.d.), a Clubhouse is described as a self-referred, safe, restorative environment for people who have experienced disruption in their lives due to living with mental illnesses. Clubhouse members work together towards common goals, such as socialization, employment or vocational rehabilitation, education, or participation in organized activities. A Clubhouse community supports its members and believes that recovery from mental illness is possible for all (International Center for

Clubhouse Development). The rationale for using a community agency in order to access the sample is that recovery does not necessarily require service providers providing mental health services (Anthony, 1993; 2000).

Initial contact.

The research participants were involved with CMHA, and therefore permission from CMHA had to be sought and granted prior to the research commencing. Contact was made with the Executive Director to discuss the research. A letter describing the research, as well as a copy of the information sheet, informed consent form, scales, and draft interview guide were given to the Executive Director for consideration (Appendix D). A letter of agency support was obtained from the Executive Director of CMHA in November 2008 (Appendix E).

After receiving written permission from the Executive Director, I arranged a meeting with Connections Clubhouse members. A weekly 'planning meeting' was then attended in December 2008 allowing me the opportunity to provide information about the study to the membership, field any questions, and ask if the study could be conducted at the Connections Clubhouse location; all 16 members present agreed to the request.

Quantitative data collection dates and times were determined and three posters were left at the study site (Appendix F). Data collection dates included the weeks of December 15, 2008 and January 5, 2009. The time frames during the data collection dates were approximately three hours per day, from about 0900 to 1200, which was inclusive of the activities that were being offered at Connection Clubhouse, so as to maximize the recruitment potential. The rationale for selecting two weeks of data collection was that some

members do not attend each week, so by selecting two weeks for data collection, a broader representation of the membership, as well as maximum participation, could be obtained.

In regard to the qualitative portion of this research, recruitment posters were displayed at Connections Clubhouse in January 2009 (Appendix G). My contact information was included so that interested participants could anonymously volunteer. A list of potential participants was gathered with basic information such as age, diagnosis, and parameters of their participation at Connections Clubhouse, as well as contact information.

Sample selection.

Criteria of the participants included: adults over the age of 19; living with a self-identified SPMI; member of Connections Clubhouse; and have a significant functional disability as a result of living with an SPMI. Functional disability was defined as having two or more psychiatric hospitalizations in the past three years or self-reported interference with housing, employment, education, or social support due to living with an SPMI (Anthony, 1993), or when a person self-reports impairment, difficulty with activities, or difficulty with involvement in life situations (WHO, 2002). The majority of individuals who access Connections Clubhouse are functionally impacted by living with an SPMI.

Research participants were competent to provide consent, as assured by the agency providing support. Additionally, the agency was contacted prior to the start of data collection to confirm all of the participants could provide consent. During this process, two individuals were flagged as incompetent, but did not come forward as participants during data collection.

A combination of purposive and snowball sampling, both non-probability, were used in this research. By using purposive sampling, the sample may be biased and unrepresentative of the population (Rubin & Babbie, 2004). However, this strategy was used

to select a sample with the potential to yield the most comprehensive understanding, based on the research question (Rubin & Babbie). A snowball sampling approach was also utilized, in that participants recruited and suggested additional participants (Neuman, 2003). Random sampling was not used in this study because of the nature of the Connections Clubhouse membership and philosophy of a drop-in center. There could have been the option to randomly sample from the interested individuals, but the sample size would have been small.

Compensation to participants.

Research participants received monetary compensation, as well as light snacks and refreshments. Transportation was offered to participants engaging in the one-on-one interviews, which were conducted at UNBC's BMO campus, in downtown Prince George. Participants who completed the scales (at Connections Clubhouse) received $10 cash. Participants who engaged in a one-on-one interview received $20 cash. It is my belief that the participants have the sought-after answers and information, and should be compensated for their time and expertise.

Data Collection and Analysis

Quantitative Data Collection

Before the quantitative data collection process began, a pre-test was completed on the demographic questions and the two scales. I sought review from one peer in the Master of Social Work (MSW) program at UNBC, who provided useful suggestions regarding wording of the demographic questions and respective choice options. The feedback with regard to the presentation of the two scales indicated no changes. One staff member from Connections Clubhouse also reviewed the quantitative package and suggested providing a 'don't know' option with regard to the demographic question about mental illness diagnosis. Upon

discussion with my supervisor, it was decided not to include that option. We wanted to try to ensure people provided a diagnosis, as membership to Connections Clubhouse is limited to people with a serious and persistent mental illness, and that is the criteria we established with regard to this study.

During data collection, all necessary preparations were made to ensure that required supplies were on hand (e.g., pencils, pens, scales, etc.). I sat with each individual as he or she filled out the scales. Some participants had the questions read aloud, verbatim, upon request. The voluntary nature of the project was stressed to participants, and they were reminded of their right to stop at any time and not lose out on their compensation. They were also told of the provisions built into the study to maintain their confidentiality and anonymity.

Quantitative Data Analysis.

The quantitative data was entered into a computer, which was password-protected, using the Statistical Package for the Social Sciences (SPSS) program (Field, 2005). Descriptive statistics, including frequency distributions and measures of central tendencies, were run on the two variables: recovery and social support. The same statistics were run on the demographic information, which included: age, gender, employment status, marital status, ethnicity, mental illness diagnosis, length of time being diagnosed, length of membership at Connections Clubhouse, frequency of participation at Connections Clubhouse, as well as duration of participation per visit at Connections Clubhouse.

I chose to execute chi-square tests, rather than Kendall's tau test, because the variables in this study are ordinal and the sample size is small (n=35). Therefore, quantitative analysis on the two variables, recovery and social support, included testing for association, which was carried out through executing Pearson's chi-square tests. According to Field

(2005), a chi-square test is used to test the independence of two variables. Chi-squares test the hypothesis that the two variables are unrelated, and is reported with a level of statistical significance. The level of statistical significance is used to report the likelihood that the results reported are due to chance factors, and that there really is no relationship, despite the data indicating one (Neuman, 2003). This significance level is reported by using a probability value, p-value, meaning that there is the probability of two variables being related. For the purpose of this research, a probability value of .05 or less ($p \leq .05$) was used, which indicates that the odds that the results are based on only chance are 5 out of 100 or less.

As mentioned previously, Pearson's chi-square tests were executed on the two variables; recovery (41-item RAS) and social support (19-item MOS: Social Support Survey Instrument). The chi-square tests produced a total of 779 associations. For the purpose of this exploratory research, significant results were cases in which the RAS statements were significantly associated with five or more (out of a possible 19) MOS: Social Support Survey Instrument items, significant at $p \leq .05$. The RAS statements that were associated with five or more MOS: Social Support Survey Instrument items, significant at $p \leq .05$, were utilized to directly inform the draft interview guide. The results of the chi-square analysis will be presented in Chapter Four.

Qualitative Data Collection

As previously mentioned, the quantitative findings were used to inform and fine-tune my interview guide by incorporating the specific significant RAS statements. Please refer to Appendix H for the original guide, and also Appendix I for the revised interview guide. Chapter Four will provide a more detailed description of how the interview guide was informed. Upon completing the quantitative data collection, I realized it would be helpful to

have an indication of each participant's current living situation. Therefore, an additional demographic question was added during the qualitative data collection phase.

The interview guide was reviewed prior to the qualitative data collection. Several people, including my UNBC MSW academic supervisor, a UNBC MSW peer, a person skilled in the area of communication, and a lay-person reviewed the interview guide, and provided wording suggestions, areas to be developed that seemed vague, and re-arrangement of the question order. Subsequent feedback included: the flow of the interview was good; the questions nicely built onto each other; and the last two questions were inviting so that people could bring forward and expand on material that earlier questions prompted. The interview guide was also pre-tested once, so that I could become familiar with the flow of the questions, but also with the functioning of the digital audio recorder.

A total of 12 people expressed interest in completing one-on-one interviews. However, only 10 participants were selected, based on meeting the objective of recruiting a relatively broad representative sample of: men/women; age; length of membership; frequency of participation; and diagnosis. Convenient meeting dates, times, and locations were individually arranged with the participants.

Ten semi-structured interviews were conducted using open-ended questions and probes. Originally, I had planned to complete five to seven interviews, as per my thesis proposal, but after completing seven interviews, I did not feel that saturation was being approached. Upon discussion with my supervisor, it was decided that I would book an additional three interviews. Following completion of the tenth interview, I felt that I was in a better position to state that I was nearing saturation as no new material was emerging from the participants.

Each interview was recorded in digital format with the participants' permission and later transcribed verbatim. All necessary preparations were made to ensure that the recording equipment was working well and that necessary supplies were on hand (e.g., batteries, paper, pencils, pens, etc.). The lengths of interviews ranged from 15 minutes to 40 minutes. After the interview transcript was prepared, I met with each interviewee to review the transcript and verify its accuracy.

Qualitative Data Analysis

Manual thematic analysis was used to analyze my qualitative data. From a broad perspective, the process of searching the qualitative data for themes is referred to as thematic analysis. Braun and Clarke (2006) acknowledge that thematic analysis is a widely used qualitative analytic method, but it is poorly demarcated and seldom recognized. Patton (2002) suggests that undertaking a thematic analysis relies on a person's ability to recognize patterns, in that the researcher is able to recognize patterns from seemingly random, sometimes disjointed information. Braun and Clarke state that a thematic analysis is a flexible method of analysis, and suggest that this approach is suitable for early researchers. Patton adds that thematic analysis, like content analysis, is "used to refer to any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings" (p. 453).

Generally, a thematic analysis is undertaken on qualitative data, and it is from the content that patterns, themes, or categories are produced. The terms 'pattern' and 'theme' require distinguishing. Generally, a pattern refers to a descriptive finding, where a theme is more of a categorical term (Patton, 2002). For example in this analysis, the theme of 'stigma' emerged, which was arrived at through patterns in the interviews, with participants

describing experiences of discrimination and stigma as highlighted by the following quotes: "I want to be treated like a person not a guy with a mental illness" and "There's not a lot of opportunity to succeed at because people have stigma". Therefore, these descriptive findings highlight an emerging pattern, and then I assigned the pattern the categorical theme of stigma.

In regard to thematic analysis, there is also the consideration of using an inductive, versus a deductive, approach to analysis. Through using an inductive analysis, the researcher discovers themes, as findings emerge out of the data; the alternate is to have a pre-established framework of patterns, themes, or categories (Patton, 2002). My research took an inductive approach, allowing the emergence of patterns and themes from the data.

The process of analysis in my research began with the transcription of the interviews. Next, I read through each of the transcripts, without taking notes, to get familiar with, and immerse myself in the data. Boyatzis (1998) suggests that, "Working directly from the raw information enhances appreciation of the information..." (p. 30). After this, I noted general thoughts that I had about potential patterns or codes. Boyatzis states, "A good thematic code is one that captures the qualitative richness of the phenomenon" (p. 31). Next, I read through the data again, using open coding, with the assistance of colored highlighters, to highlight repetitive words or phrases. I also took notes on emerging themes or concepts. As the themes started to emerge, I re-read through the data, using an aspect of constant comparison, to see if similar themes were emerging across the data set.

Next, I grouped all the patterns together to form a list of potential themes. When choosing the wording for my themes, I tried to be conceptually meaningful, clear, concise, and close with regard to wording as used in the data, as suggested by Boyatzis (1998). This

proved to be a lengthy process, and originally produced a total of 16 themes. The 16 themes were reviewed and eventually reduced down to five themes. I then returned to the data one more time to verify and supplement these five key findings.

Ultimately, to answer the question about the relationship between recovery and social support, I had to describe the themes that were related to recovery and the themes that were related to social support. This was accomplished through creating a diagram; to visually display the unique and common themes for recovery and social support (see Figure 1, page 74). Through analysis of each of the individual interview transcripts, units of meaning were produced, and ultimately placed into provisional thematic categories. Direct quotes from the interview data were used in order to support the findings from the data analysis.

Throughout the process of reading through the transcripts, highlighting, taking notes, and reflecting, I maintained a research journal to document my experiences of the data analysis process. It is argued that the researcher must become immersed in the data to be best able to identify patterns, themes, and categories within the data (Boyatzis, 1998; Braun & Clarke, 2006). Such immersion can compromise the research process, thus it is important to demonstrate rigor, which is the next topic for discussion.

Credibility and Trustworthiness

When conducting research, it is important to establish credibility and trustworthiness with one's reader (Caelli, Ray, & Mill, 2003; Fereday & Muir-Cochrane, 2006; Patton, 2002; Schwandt 1997 & 2001; Tobin & Begley, 2004). Trustworthiness has traditionally been addressed by speaking to the following issues: triangulation, reliability, validity, and rigor. However, these terms have been borrowed from the quantitative, or positivist, paradigm. Quantitative researchers have been able to 'test' and 'assure' reliability and validity, and the

expectation has been similar in the qualitative realm. Qualitative researchers wish to establish credibility too, but it has to be addressed in a different way. This section will outline the measures I took to make this research credible, including my approach to triangulation and rigor.

Triangulation can be simply described as "using multiple methods to view a single object" (Huettman, 1993, p. 42). Despite its seemingly simple definition, triangulation is important in that it adds strength to the research, as well as its findings or conclusions (Patton, 2002; Yin, 1984). Four types of triangulation have been identified: data/method; theory/perspective; investigator/analyst; and methodological/source (Farmer, Robinson, Elliott, & Eyles, 2006; Huettman; Lincoln & Guba, 1985). Two types of triangulation were employed in my research: data/method triangulation and methodological/source triangulation. I used two different methods to collect data: scales and interviews. And with respect to source triangulation, I met with each interview participant to review and verify the interview transcript.

There is an argument about the intent of triangulation, and whether it is used to establish completeness or confirmation. With respect to qualitative research, and coming from a constructivist framework where multiple realities or truths exist, the intent should be completeness (Tobin & Begley, 2004). By using triangulation, I was striving for 'completeness', rather than confirmation, as I employed my two methods, as well as checked with the participants about the data. Confirmability, as discussed by Cutleff and McKenna (1999), is the "...underlying supposition is that confirmation is necessary to establish truth. Assumption of one reality, and consequently a measure of accuracy as a means of validating this truth, is epistemologically unacceptable from a qualitative perspective" (p. 393, as cited

in Tobin & Begley). Triangulation was used in my research to establish completeness, which Tobin and Begley suggest is a good way to ensure quality in qualitative research and "as a means of enlarging the landscape of their inquiry, offering a deeper and more comprehensive picture" (p. 393).

The concept of an audit trail, which is the provision of the necessary evidence documenting the research process, can be used to demonstrate credibility or trustworthiness of the research (Koch, 1994). Schwandt (2001) adds that an audit trail is a "systematically maintained documentation system" (p. 9) and "can be used to attest to the use of dependable procedures and generation of confirmable findings on the part of the inquirer" (Schwandt, 1997, p. 6). Therefore, by maintaining detailed notes of my research process, an independent person could potentially review my process and render a judgment about the dependability of my procedures, and ultimately my results.

Patton (2002) suggests three strategies for enhancing the quality and credibility of qualitative inquiry: rigourous methods; the philosophical belief in the value of qualitative inquiry; and the credibility of the researcher. Rigor is defined as "the way we demonstrate integrity and competence and legitimacy of the research process" (Tobin & Begley, 2004, p. 390). Although rigor has been borrowed from the positivist paradigm, there are indeed ways to establish rigor when using qualitative inquiry, including maintaining research journals, being reflexive, and clearly documenting the process of data analysis (Patton). Having a clearly documented approach to rigor is important for building credibility (Caelli et al., 2003). I believe that qualitative inquiry is invaluable, insofar as moving our thinking forward and exploring areas that have been essentially untapped. Neuman (2003) suggests that qualitative researchers are not so much interested in validity, but more so the idea of

authenticity, which he says "gives a fair, honest and balanced account of social life from the viewpoint of someone who lives it everyday" (p. 185). That is why from a naturalistic inquiry viewpoint, a researcher should strive for completeness, rather than confirmation, so that these accounts of people living their lives have a voice. And finally, with regard to the credibility of the researcher, I would suggest that I am credible in the area of adult community mental health, in that I have eight years direct experience working with the population that participated in my research. As well, I am conducting this research from a credible university, and I received regular supervision from my supervisor. Finally, I had to complete UNBC's ethics process, as discussed in the next section.

Ethics

An application was made to the University of Northern British Columbia's Research Ethics Board, as per UNBC's policy regarding research involving human participants. Approval for this research study was granted by UNBC's Research Ethics Board on November 27, 2008 (Appendix J).

Each research participant, whether participating in completing the scales or the one-on-one interviews, received an information sheet (Appendix K and Appendix L) and provided informed consent in writing (Appendix M and Appendix N). Confidentiality and anonymity were discussed, in that no identifying data were included on the scales or the interview transcripts and that the information gathered was used collectively, rather than individually. To further protect interview participants' confidentiality, they either chose, or were assigned, fictitious names.

The collected data was stored in a locked filing cabinet in the office of my academic supervisor. The data will be destroyed two years after the thesis is successfully defended.

Scales and interview transcripts will be shredded, digital interview files will be deleted, as will all computer files containing both the qualitative and quantitative data.

It was reinforced to each participant that involvement in the research study was completely voluntary, that the participant could stop at any time, and that withdrawing participation would not affect compensation, membership, participation, or access to Connections Clubhouse. As well, it was stressed to the participants that information learned about them would not affect their services, nor would I use the information to impact the program service with which I was associated.

I recognized there was the possibility of my staff role impacting research participants both positively and negatively. As mentioned, throughout the data collection process, it was reinforced to the research participants that participating, withdrawing participation, or choosing not to participate would not impact their services from CMHA or myself in any way. To prevent me from blurring my roles, I maintained a reflexive research journal, which was mentioned in Chapter One. Additional potential impacts from this thesis research study are discussed in Chapter Six in the limitations section.

Debriefing took place with each participant from phase one and phase two. There was one participant who withdrew participation in phase one. He became visibly upset during completion of the scale, so we talked about what was going on for him and at the end he remarked, "you have to expect it working with people like us". He denied needing to speak to his case manager. Staff members were informed about the participants' response to the research. The rest of the participants did not seem distressed nor felt they needed further debriefing. However, phone numbers for Northern Health Authority, Mental Health and Addictions Services and the Community Response Unit were on hand.

In summary, this chapter has explored the nature of my thesis research, including the process of the study involving two distinct phases of data collection. The study participants were clearly identified, and the data collection and analysis procedures and processes were explained. Issues of credibility, trustworthiness, and ethics were also discussed. The next chapter will report the findings, including the demographic information of participants from both phases. As well, the unique and common themes identified by the study participants with regards to the two variables, recovery and social support, will be highlighted.

Chapter Four: Research Findings/Discoveries

The following chapter will highlight the findings of my exploratory mixed-methods research. Phase one included the quantitative method, which incorporated the use of two scales. The demographic information was presented using descriptive statistics, including measures of central tendency and frequencies. The quantitative findings will be highlighted; in particular, their influence on the interview guide. Phase two included the qualitative method, which incorporated the use of one-on-one semi-structured interviews. The demographic information is presented along with the five emergent themes from the thematic analysis. From the analysis in phase two, a diagram was created which visually displays both the unique and common themes with respect to the variables recovery and social support, ultimately highlighting the relationship between the two variables.

Phase One

Demographic Data

Thirty-five men and women completed the Recovery Assessment Scale and Social Support Survey Instrument, and provided basic demographic information. The age range was 21 to 59 years, with a mean age of 45 years, and a standard deviation of 10 years. There were 23 males (65.7%) and 12 females (34.3%).

The majority of participants, 23 (65.7%), indicated that they work. Of the 23 participants, 14 (60.9%) were males and nine (39.1%) were females. The working participants included a brief description of their jobs. Work has been commonly identified by participants as volunteer work (most often at a mental health location) or less commonly, paid work in the community. Participants indicated the following volunteer work sites: Activity Center for Empowerment (ACE), Connections Clubhouse, and Iris House. These

three places are engaged in the Northern Health Authority's Mental Health and Addictions Services, Vocational Rehabilitation Program. Some participants mentioned that they work at more than one site, including the Vocational Rehabilitation Program, and also paid work in the community. The following is a summary of work descriptions: ACE doing various clean-up jobs; Connections Clubhouse doing reception, cooking, dishes, and moving company work; Iris House doing janitorial work; CMHA volunteering in the thrift store 'Second Chance'; and paid work in the community at various businesses including home building supply stores, restaurants, janitorial companies, and call centers.

With regard to marital status, the majority of participants were single (54.3%). No participants chose the dating or common-law options. A total of 28 participants (80%) identified their ethnicity as Caucasian. Two participants chose the 'other' option, but were included in the Caucasian category as participants were Canada-born and their parents were of European heritage. The other 20% (seven participants) indicated they were Aboriginal.

With respect to mental illness diagnosis, 14 participants (40%) identified their illness as schizophrenia. Two participants indicated two mental illness diagnoses, including the diagnosis of 'other'. This creates the column sums to be greater than the sample size, as well as a percentage of greater than 100%. Explanations of other mental illness diagnoses included: borderline personality disorder/traits; intermittent explosive disorder; fetal alcohol effects; emotional stress and pain; and obsessive-compulsive disorder. Please refer to Table 1.

Table 1

Demographic Information for Phase One Participants (n=35)

Age (years)	Range	21-59
	Mean	45
	Standard deviation	10

Demographic Characteristics		n	%
Gender	Male	23	65.7
	Female	12	34.3
Employment status	Working	23	65.7
	Not working	12	34.3
Marital status	Single	19	54.3
	Divorced	4	11.4
	Widowed	1	2.9
	Married	6	17.1
	Separated	5	14.3
Ethnicity	Caucasian	28	80.0
	Aboriginal	7	20.0
Mental illness diagnosis	Schizophrenia	14	40.0
	Bi-polar disorder	5	14.3
	Schizo-affective disorder	4	11.4
	Depression	2	5.7
	Anxiety	2	5.7
	Depression/anxiety	4	11.4
	Other	6	17.1

Additional demographic information was gathered on participants, including length of time since mental illness diagnosis, length of membership at Connections Clubhouse, as well as frequency and duration of participation at Connctions Clubhouse. The mean mental illness diagnosis length was 14 years, seven months, and the range was three months to 39 years. The mean length of membership at Connections Clubhouse was eight years, and the range was one month to 25 years. Participants' frequency of participation ranged from three times/month to five days/week, with the mean frequency of participation being three days/week. Participants' duration of stay ranged from one to six hours, with a mean stay of three hours and fifteen minutes. Please refer to Appendix O for more details on phase one participant demographic data.

Findings

Participants who engaged in the quantitative phase (phase one) of the thesis research completed two scales: Recovery Assessment Scale (RAS) and Social Support Survey Instrument (SSS). As discussed in Chapter Three, scoring for both scales was simple summation. With respect to the RAS, the answers for the 41 items are summed, producing a total score. The highest possible score that can be achieved is 205 and the lowest possible score is 41. According to Corrigan et al. (1999), the total score has been shown to positively associate with empowerment, coping ability, and quality of life, and inversely associate with psychiatric symptoms. And in regard to the SSS, the average score can be calculated for each of the four sub-scales or overall, which suggests the overall functional social support index. The highest possible score that can be achieved is 95, and the lowest possible score is 19. The higher the score for an individual sub-scale, or for the overall support index, the higher level of support indicated (Hays et al., 1995). The results are displayed in Table 2.

Table 2

Measures of Central Tendency for Phase One Responses (n=35)

	RAS	SSS
Range	123 - 198	41 - 95
Mean	162	65
Median	159	64
Mode	150	67
Standard Deviation	19.2	13.8

The range of scores for the RAS were 123 to 198, with a mean score of 162, and a standard deviation of 19.2. The median was 159 and the mode was 150. With respect to the SSS findings, the range of scores was 41 to 95, with a mean score of 65, and a standard deviation of 13.8. The median was 64 and the mode was 67. These findings seem to indicate participants have feelings of empowerment, coping ability, quality of life, and social support, as well as limited psychiatric symptoms.

Table 3 displays the descriptive statistics for each of the four sub-scales of social support. The maximum score for each sub-type of support was achieved. Interestingly, the mode for tangible support was the maximum score a participant could achieve, indicating a high level of perceived tangible support amongst the participants.

Table 3

Measures of Central Tendency for Sub-types of Social Support

	Emotional/ information n=34	Tangible n=35	Affectionate n=34	Positive social interaction n=35	Additional item n=35
Range	18 - 40	4 - 20	3 - 15	3 - 15	1 - 5
Mean	28.1	12.5	10.3	10.4	3.3
Median	27	13	12	10	3
Mode	24	20	12	9	3
Standard deviation	6	5.1	3.7	3.3	1.2

As previously mentioned, the intent of using the Recovery Assessment Scale and Social Support Survey Instrument was to inform the draft interview guide. Chi-square tests were executed on the two variables; recovery (41-item RAS) and social support (19-item SSS). A total of 779 associations were produced. For the purpose of this exploratory research, significant results were cases in which the RAS statements were significantly associated with five or more (out of a possible 19) SSS items ($p \leq .05$). Upon reviewing the associations, there were 11 RAS statements that met this criterion. The RAS statements were then placed directly into the draft interview guide (Appendix H), creating the revised interview guide (Appendix I). The 11 Recovery Assessment Scale statements are as follows:

- I have a desire to succeed.
- I know that there are mental health services that do help me.
- I like myself.
- If I keep trying I will continue to get better.
- Things happen for a reason.
- Something good will eventually happen.
- It is important to have fun.
- I know when to ask for help.

- I have people I can count on.
- Even when I don't believe in myself, other people do.
- It is important to have a variety of friends.

Please refer to Appendix P for the specific values and details of item pairs.

Phase Two

Demographic Data

With regard to the phase two participants, a representative sample of the Connections Clubhouse population was obtained. Table 4 displays the demographic information of the participants. The age range was 21 to 57 years, with a mean age of 47 years, and a standard deviation of 11 years. There were six male (60%) and four female (40%) participants. The majority of participants, seven (70%), indicated that they were working. Job descriptions included: volunteering one to two days/week; ACE two days/week; volunteering at Connections Clubhouse; and Iris House janitorial work.

Living status showed a majority of participants live with somebody. Six participants (60%) identified living with a roommate, family member, or spouse, while the other four participants identified living alone. With regard to marital status, single marital status was the most frequently reported, with four participants (40%) choosing this option. There were three married participants (30%). Ethnicity resulted in eight (80%) of the participants indicating Caucasian, and two (20%) indicating Aboriginal. A total of seven participants (70%) indicated the following three illnesses: schizophrenia (20%), bi-polar disorder (20%), and schizo-affective disorder (30%). Two participants indicated two mental illness diagnoses, including the diagnosis of 'other', explaining having borderline personality disorder/traits. This creates the column sum to be greater than the sample size, as well as greater than 100%.

Table 4

Demographic Information for Phase Two Participants (n=10)

Age (years)	Range	21-57	
	Mean	47	
	Standard deviation	11	
Demographic Characteristics		n	%
Gender	Male	6	60
	Female	4	40
Employment status	Working	7	70
	Not working	3	30
Living Status	Alone	4	40
	With roommate	2	20
	Family member	1	10
	Other (spouse)	3	30
Marital Status	Single	4	40
	Divorced	2	20
	Married	3	30
	Dating	1	10
Ethnicity	Caucasian	8	80
	Aboriginal	2	20
Mental Illness Diagnosis	Schizophrenia	2	20
	Bi-polar Disorder	2	20
	Schizo-affective Disorder	3	30
	Depression and Anxiety	2	20
	Other	3	30

As with phase one participants, additional demographic information was also gathered on phase two participants, including length of time since mental illness diagnosis, length of membership at Connections Clubhouse, as well as frequency and duration of participation at Connctions Clubhouse. The mean mental illness diagnosis length was 18

years, seven months, and the range was six years to 38 years. The mean length of membership was almost 11 years, and the range was 10 months to 25 years. Participant's frequency of participation ranged from one day/week to five days/week, with the mean frequency of participation being two and one half days/week. Participant's duration of stay ranged from one hour to eight hours, with a mean stay of three hours and forty minutes. Please refer to Appendix O for more details on phase two participant demographic data.

Findings

The subsequent section highlights the emergent themes following an inductive thematic analysis that was conducted on the interview transcripts. The intent of the interviews was to answer the research question, 'What is the relationship between recovery and social support for individual living with a serious and persistent mental illness?', as well as to fulfill a secondary objective of creating the beginning of a definition of social support from the perspectives of individuals living with an SPMI.

In order to answer the research question, the two variables were defined and described by the interview participants. As previously noted in this chapter, in addition to the textually described thematic analysis, I created a diagram to visually display both the unique and common themes for recovery and social support (see Figure 1, page 74). From the definitions and descriptions of recovery and social support, statements and themes that were described by participants as part of both recovery and social support provided a view of the overlap between the two variables and thus, a glimpse of the relationship. I described each of the emergent themes evident in recovery as well as those evident in social support. Social support themes provided the beginnings of a participant-identified definition of social support – a secondary objective of my research.

The thematic analysis that was undertaken with the data (complete description of the process is presented in Chapter Three) resulted in the emergence of the following five themes (the numeric order of the themes does not indicate a ranking):

1. Work/volunteer opportunities
2. Mental Health Services
3. Peers
4. Connectedness
5. Stigma

Direct quotations will be used to highlight aspects of the themes. Fictitious names were either chosen by, or assigned to participants to ensure confidentiality. There was some overlap between the themes, which will be noted and discussed.

Themes.

1. Work/volunteer opportunities

Participants indicated that having work/volunteer opportunities was a source of social support; attending the physical location of the work/volunteer site, the people or co-volunteers/workers, as well as the staff present at supported work sites. Having those same opportunities also contributed to recovery in that it provided something structured to do and gave a sense of purpose.

"Where you do volunteer work...the staff...that's all social support to me." Amy

"When we go volunteer twice a week there is always social support there." Lenny

As well, having volunteer opportunities has been helpful when individuals have been unwell mentally.

"What has helped me when I've been ill is volunteering." Kim

"I can ask my employers in mental health (Connections Clubhouse) for help." Ken

The terms 'work' and 'volunteer' were often used interchangeably. Many of the work opportunities that were mentioned by participants included Vocational Rehabilitation programming ultimately funded through the Northern Health Authority, including Connections Clubhouse and Activity Center for Empowerment (ACE).

"I volunteer on the social committee." Lance

"I am working at a place called Connections Clubhouse." Kim

Participants seemed to view work/volunteer roles as a source of connectedness. By having the opportunity to engage in such activity, but also to be around people, provided a sense of connection. As many of the work/volunteer opportunities were at Connections Clubhouse, there was the added sense of community as people could socialize, but also do their work/volunteerism.

2. Mental Health Services

Involvement with mental health services seemed important to the interview participants. Participants recognized that having a mental health service provider in their lives assisted in their recovery journeys, but also noted that social support was often provided by the very same mental health services. Mental health services included: case managers on the Community Outreach and Assertive Services Team (COAST) or Community Acute Stabilization Team (CAST); doctors at COAST; psychiatrists; lifeskills support workers; ACE; and Connections Clubhouse. Various mental health programs that were described included: housing subsidies; lifeskills support program; ACE; Connections Clubhouse; and CMHA. When describing their involvement with mental health services, either the names of specific people or programs were mentioned.

"I just see my doctor and Lisa (fictitious name)." Rustin

" I have a worker...from Connections Clubhouse ...and from northern health unit." Lorraine

" She's a team leader." Amy

Some participants did not know with which 'team' their case managers or support people were associated. Because I have worked in community mental health, I was aware of the case managers and their associated teams, and was able to determine the particular team they were referring to.

When I asked about involvement with mental health services, I did not delineate between formal services, such as Northern Health Authority, Mental Health and Addictions Services (COAST/CAST teams), or informal mental health services, such as Connections Clubhouse or ACE. Participants did not seem to note a distinction, lumping all services together.

"They're a source that I can go to for help...whether it is Canadian Mental Health or...what do they call it...CAST I guess." Nancy

"I have a psychiatrist...and I work at a place called Connections Clubhouse." Kim

"Not mental health per se but Connections Clubhouse." Daniel

Participants described the function or role that mental health services provide in their lives. There were varied responses, including providing information or emotional support, providing general assistance, and providing referrals and/or resources.

"Lifeline...only got you guys and it's been very helpful." Ken

"Have a sounding board." Stewart

"Others believe in you...it's really thoughtful of them...sometimes I think I've been treated rude or wrong and they talk to you about it." Ken

"They help me because they get me into groups like gardening and cooking...you can learn to cope with other people and cope with yourself." Lorraine

"They are a source that I can go to for help." Nancy

"Mental health services is a great support system...if I have questions or run into trouble I have a resource to go to." Amy

According to the majority of participants, overall they were satisfied with the amount of contact or service they receive from mental health services.

"They pretty much leave me on my own unless I need to talk to someone." Lance

Some participants expressed dissatisfaction about mental health services, including that services are not always available, for example on weekends, and that a person does not necessarily meet criteria for either the service itself or a particular program within the service.

"As far as mental health per se the office down town (Canadian Mental Health Association) they have not done one thing for me." Daniel

"Well when you need help there's no one to phone...after hours... when you need support personally it doesn't happen cause there's no one there." Lenny

"I went back for some help...s/he said well you're high functioning you don't really need anything...and I was discharged from the mental health circle." Stewart

"Sometimes don't help as much as I would like them to." Nancy

"A lot of times phone calls aren't returned and I have to accept that." Lenny

"It's sad because I know if I'm not getting it (services) there's lots of other people that need it (services) without a doubt that aren't getting it." Daniel

3. Peers

Participants had many ideas about peers, including who their peers are, roles of peers, the idea of peer-ship being reciprocal and perceived, as well as the function of having peers with mental illness. Several participants mentioned that they do not have many friends.

Participants explained that social support was often provided by peers, and also suggested that peers assist in the recovery process in a variety of ways such as by being someone to talk to or someone to whom they provide support.

Participants identified that peer-ship is a reciprocal process, in that being around people provided the opportunity to give back and help others.

> *"Using what I have when I'm well to benefit other people...sometimes I feel it's almost my responsibility...that I've been helped so I should help."* Stewart

> *"Sit down and talk to people about what they got or what you have or how you can help them or how they can help you."* Daniel

> *"My support is helping others too...it works hand in hand you know what I mean it's like plugging in an appliance it needs to be plugged in to work but it works hand in hand."* Lenny

Having a perceived connection to people was highlighted in the following way:

> *"Well I don't have that many friends here in BC...so many of them are back home."* Amy

> *"Well I phone them once and a while here and there."* Ken

> *"Being able to talk to them (lifeskills workers) and they're knowledgeable and they're open to being talked to. Do you currently have a lifeskills worker? No."* Nancy

Participants identified that having friends or peers that have similar situations, in that they live with or experience mental illness, is helpful. Rationale for being helpful included: people can understand and maybe relate; decreased feelings of isolation or uniqueness; and simply being in the presence of others who live with a mental illness.

> *"We just go with other people just to...know how we can help each other and support each other like with thoughts and things like that."* Ken

> *"Can socialize with other people who have some kind of mental illness."* Rustin

> *"People who understand what's going on and hopefully relate."* Stewart

> *"In a way it gives me the feeling that I'm not the only one."* Lenny

"My friends are other people in our system." Ken

"There are other people in the system they have problems you know...we have friendships and things like that." Kim

With respect to participants mentioning that they do not have many friends, the following was said:

"I don't have very many good friends." Stewart

"I don't think I have any anymore...no I've lost count of my old associates." Lenny

"I don't have a lot of close friends...probably not any close friends at all." Rustin

4. Connectedness

Having a sense of connectedness seemed to have several aspects and functions, as well as a relationship to other themes. Participants explained that simply being around people was important because the presence of people served to support them.

"I believe that it can be beneficial to talk to people about how you're feeling and get feedback on mental illness." Kim

"Everybody you know is kinda reassuring...makes you feel good." Ken

"I started hearing stories that were far worse than mine...look this persons' got this problem and she's coping with it, it's worse than yours why can't you cope with yours?" Daniel

By having a place to go, such as Connections Clubhouse, there has been the provision of a sense of belonging and community, but also an avenue for activities.

"You know you can end up hibernating yourself out there...it's good to get out and talk with people...all I regularly do is attend the clubhouse so ya it's important to me." Nancy

"Connections Clubhouse is a place where people with mental illness come and they can volunteer their time...it helps them to feel like they are contributing to the community." Kim

"There's a lot of acquaintances through the Clubhouse." Rustin

"Gives me a reason to get out of bed in the morning." Stewart

As well, it seems that Connections Clubhouse may be a catalyst for friendships and socialization, even after Clubhouse hours.

"I socialize with them by just seeing them at that center (Connections Clubhouse)...saying hi in the morning." Lance

"There's other people in our system." Ken

"I met him through the Clubhouse last year and we got along really well and we do things after Clubhouse hours...movies and dinner." Stewart

"Having a place that is not demeaning and people aren't ridiculing you." Lenny

However, participants mentioned that they might not need Connections Clubhouse in the future.

"Right now it does but I don't know whether it will a year from now." Nancy

"It did at one time but not so much any more." Amy

The interconnectedness between recovery and social support was highlighted when participants mentioned that having a connection to mental health services, a connection to work or volunteering, and a connection to peers were all important to them. Thus, these connections serve multiple purposes, by creating a sense of community, as well as a sense of belonging and purpose. Ultimately, a sense of connectedness and having a sense of belonging and purpose seemed critical to both an individual's recovery and social support.

5. Stigma

This topic was not explored directly via the interview guide, nor was it directly related to the relationship between recovery and social support. But it was woven throughout participants' lives and journeys. Participants mentioned various experiences or circumstances

about stigma or discrimination that they have experienced while living with a mental illness, including internal, societal, and lateral.

Internal stigma was highlighted by statements about personal inadequacy due to living with a mental illness.

> *"I didn't want anybody to know that I wasn't this super guy that they thought I was."* Daniel

> *"It was hard for me to accept the fact that I wasn't Joe cool and it actually happened ...I denied it and denied it and told the doctor he was a goof all because I wouldn't accept the fact. Coulda been I was ashamed that I wasn't the super person everybody thought I was."* Daniel

Societal stigma was described as experiences of discrimination in general.

> *"I gotta learn you can't get too much out of society that way you just gotta go on your own and live on your own as smart as you can."* Ken

> *"It doesn't look like there's a lot of opportunity out there really to succeed at...people have a little bit of stigma...I think a lot of people."* Rustin

> *"It kinda seems really nice that they recognize the person. Recognize the person instead of what? A guy with an illness."* Ken

> *"It's unfair what they do to people who have a disability."* Lenny

> *"One worker...she had a nickname of Riverview as being the farm...the mother farm...where the coconuts come from...where the mentally ill stay."* Rustin

Lastly, lateral discrimination was indicated when a participant made discriminating remarks about the population for which he or she is also a member.

> *"I do have friends in mental health but they aren't people I would normally go out with."* Nancy

> *"Like I remember years ago when I was committed to 3NE...some of the groups of people that are still around came up to visit me and one gentleman there says to me you call those friends? They look like criminals and I sorta thought maybe I should take a moment and decide if I really want to be there you know? Like maybe I should find some more legit people."* Lenny

> *"Try not to use your mental illness as a crutch...like if they get in trouble they'll be like well it's not my fault cause I'm bipolar and all that and that's not right."*
> Lorraine

Recovery.

There were several unique themes that emerged from the data with respect to recovery (see Figure 1, page 74). Recovery was identified as being a process, in that it is gradual, ongoing, and can be compared to a ladder, with various rungs, on which one moves up and down. Several components of recovery were identified, including emotional, physical, and spiritual components. The emotional component was described as the ability to cope with one's self, to create and maintain a positive attitude, and to reach a place of acceptance within one's self. The physical component included taking medication, and living and managing on one's own. The spiritual component included the idea of karma, and reliance on the Lord.

Social support: Defined.

From the thematic analysis, the following themes emerged with respect to the topic of social support, creating the foundation for a definition of social support from the perspectives of individuals living with an SPMI:

> The perception of having a system of family, friends, community mental health (formal or informal), work/volunteer opportunities, or community agencies, available to talk or engage in activities. The system is comprised of the whole network or team of support people. Having a system of social support can provide a reason to get out of bed in the morning, become or stay involved, improve daily activity, and keep active. Social support can act as a lifeline, provide reassurance, or create a sense of connectedness. Social support is provided during good times and bad times. Support

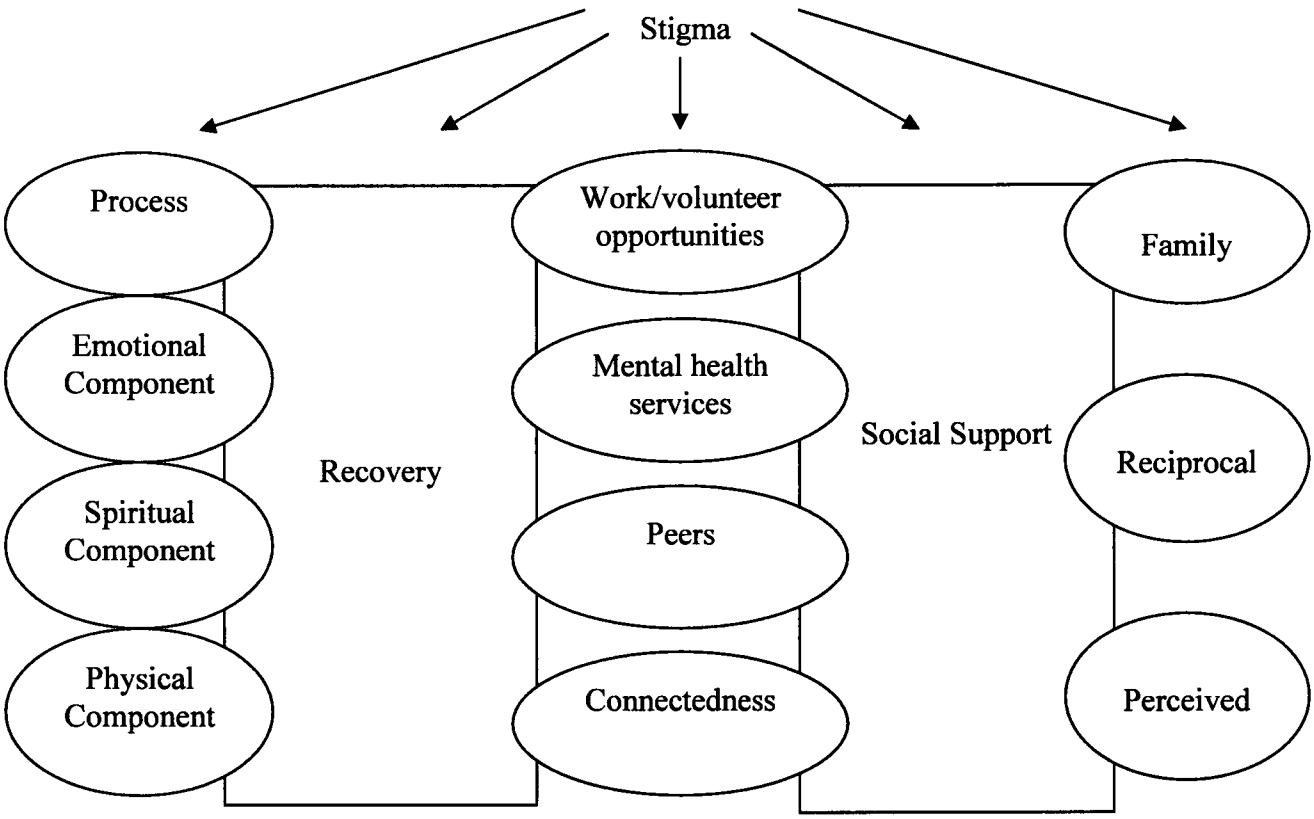
can be provided when people are having a hard time relating or understanding what is going on, but also to have fun and engage in activities. Giving and receiving social support amongst peers with mental illness is important in that it gives the sense that 'I'm not the only one', and that people in similar situations can understand and relate to what is going on. It is important to support others, rather than solely receive support.

Relationship.

As referenced several times throughout this thesis, a diagram was developed to visually display both the unique and common themes for the variables recovery and social support (see Figure 1, page 74). It is from the common themes that the relationship between recovery and social support was identified. The unique themes were discussed and highlighted at length previously in this chapter. The purpose was not to suggest that the common themes occur in isolation. Therefore, the following section will provide a discussion about the overlap amongst the common themes; a creation of a complex and intricate relationship web.

Figure 1

Diagram of the Relationship Between Recovery and Social Support



Stigma seemed to pervade through an individual's recovery journey, but also when accessing social support. It was pointed out that several levels of stigma, including internal, societal, and lateral have impacted participants. Due to the effects of stigma, participants were impacted on various fronts, including opportunities for work/volunteering, accessing mental health services, peers, and gaining a sense of connectedness.

The work/volunteer theme overlapped with every other theme. Work/volunteer opportunities seemed to overlap with peers, as participants indicated they had friends at work/volunteer sites. Also, participants explained that many of their peers also lived with a

mental illness. Several participants identified their work site as involved with mental health services, so would not only be exposed to other people who live with a mental illness, but also recognize their like-involvement with mental health services. Work/volunteer opportunities overlapped with connectedness, as participants identified that work/volunteer opportunities create the opportunity for feelings of belonging and connection with other people. In many instances, their work site was also their socialization site, for example, Connections Clubhouse.

With regard to mental health services, participants were inclusive of the various mental health services, including services provided by Northern Health Authority, as well as community mental health services, such as Connections Clubhouse, which is run by the Canadian Mental Health Association. Therefore, when speaking about mental health services being important for recovery, but also for social support, participants thought of these various mental health service providers. When thinking of mental health services in these broad terms, there is overlap with the other themes because participants recognized mental health services as a referral source, so could gain access to work/volunteer opportunities. As well, groups are organized through mental health services, so can provide access to peers, but also create a sense of connectedness and belonging when individuals are engaging in activities together, such as gardening, bowling, or cooking.

As mentioned, the themes of peers and connectedness were interwoven with work/volunteer opportunities and mental health services. There seemed to be a strong sense of connection and community amongst the participants. The explanation of the relationship between recovery and social support has proven to be complex and intricate, with much overlap between the common themes.

Many avenues and opportunities for discussion have been highlighted in the presentation of the results from my thesis research. The next chapter will restate the research question and objectives, and then engage in an exploration of the quantitative and qualitative findings. Linkages to the literature that was presented in Chapter Two will also be made.

Chapter Five: Discussion

The following chapter will provide a discussion of my thesis research findings and discoveries, augmented by relevant literature. I will first discuss the five emergent themes, followed by the concept of recovery, and lastly social support.

As previously stated in Chapter One, the intent of my research was to explore the relationship between an individual's recovery journey, in regard to serious and persistent mental illness, and social support. Therefore, the research question was: What is the relationship between recovery and social support for individuals living with a serious and persistent mental illness? The following research objectives were pursued:

1. Inform the qualitative interview guide based upon results from standardized measures for self-reported recovery and social support of individuals living with an SPMI.
2. Explore the relationship between recovery and social support.
3. Identify themes from individuals' personal stories of social support, and from this data develop a definition of social support based on research participants' perspectives.

The first objective was achieved through phase one of the research, which employed a quantitative method. Thirty-five participants completed two scales; the Recovery Assessment Scale (RAS) and the Social Support Survey Instrument (SSS). The quantitative data analysis included executing chi square tests. Significant results were identified when an RAS statement was paired with five or more SSS items, significant at $p \leq .05$. The results produced 11 significant statements, including:

- I have a desire to succeed.
- I know that there are mental health services that do help me.

- I like myself.
- If I keep trying I will continue to get better.
- Things happen for a reason.
- Something good will eventually happen.
- It is important to have fun.
- I know when to ask for help.
- I have people I can count on.
- Even when I don't believe in myself, other people do.
- It is important to have a variety of friends.

The 11 statements were incorporated into the draft interview guide.

Phase two included using a qualitative method, specifically one-on-one interviews. The thematic analysis that was undertaken sought to answer the remaining research objectives, including exploration of the relationship between the two variables and the creation of a definition of social support. A diagram to visually display the unique and common themes of recovery and social support was created (see Figure 1, page 74). The subsequent discussion will integrate the findings from phase one, as well as from phase two.

Exploring the Relationship

The second objective was to explore the relationship between recovery and social support. After both phases of data collection were complete, I started to re-think the research question, and queried if I had framed my research question in a reasonable or attainable manner. I found it challenging to analyze the data in a meaningful way, solely using text while at the same time, trying to stay focused on the task at hand of answering a relationship-natured question. Therefore, I organized the data using a visual display, highlighting the unique and common themes of both recovery and social support (see Figure 1, page 74). Four themes emerged, linking the two concepts of recovery and social support: work/volunteer opportunities; mental health services; peers; and connectedness. The fifth theme was stigma, which seemed to weave both within and between the two variables.

Work/volunteer Opportunities

With respect to the demographics of the participants within the quantitative and qualitative phases of data collection, the majority of participants in both phases indicated that they worked, 65% and 70% respectively. I was surprised when this was the sole theme that was not supported by the quantitative analysis, as indicated by the limited associations in this area between the Recovery Assessment Scale and the Social Support Survey Instrument. The Recovery Assessment Scale statement, specific to the theme of work/volunteer opportunities, was: Item #33 – "Being able to work is important to me". Surprisingly, this statement was only associated with one Social Support Survey Instrument item during the quantitative data analysis phase. But during the qualitative data analysis phase, it emerged as a theme.

In regard to language, I have recognized that the terms 'work' and 'volunteer' were used interchangeably. According to the participants, work was the term used regardless of whether the participant was working or volunteering. Additionally, the 'work' that was described was often within the mental health system; Connections Clubhouse or ACE or some other way through Northern Health Authority's, Mental Health and Addictions Services, Vocational Rehabilitation Program. Many participants acknowledged being a recipient of an honorarium, which includes $100/month to offset any costs associated with the placement, such as transportation. While I was surprised that participants used the terms 'work' and 'volunteer' interchangeably, I would suggest that language is unimportant. Rather the important aspect is that the people have a regular place where they feel they contribute, where they feel connected, and where they achieve a sense of purpose.

With respect to the original literature review, there was limited focus on work or volunteer opportunities. However, after the work/volunteer opportunity theme emerged from

my data, I returned to the literature, and found there has been some focus on the role that work plays in an individual's recovery journey. There is also literature on the topic of sheltered workshops, which in some ways, I believe could be equivalent to the Vocational Rehabilitation Program. Dunn, Wewiorski, and Rogers (2008) explored the meaning and importance of employment to individuals living with an SPMI. They found two themes, including: work has personal meaning, and more significant to my research, that work promotes recovery. Dunn et al. found that work promotes recovery because it increases self-esteem, helps people cope with their illness symptoms, and promotes financial self-sufficiency through facilitating independence from public benefits. Through the structure and routine that work offers, recovery is promoted and the individual benefits from the intangible experiences seemingly unavailable elsewhere. I recognize that this study focused on paid work, but I believe the themes could be relevant for either paid or unpaid work. Rogers et al. (2004) agree with Dunn et al.'s findings, asserting that work is a critical element for recovery because work increases self-esteem, and provides a sense of purpose and accomplishment. Provencher, Gregg, Crawfod, and Mueser (2002) also agree, emphasizing that work is closely linked to an individual's experience of recovery in that work provides a means of self-empowerment and also promotes a sense of self-actualization.

Participants stressed the positive connection they felt, and the sense of routine and purpose that emerged from having regular 'work'. The financial aspect was different for the individuals I interviewed, perhaps because of the federal and provincial benefits system. Individuals focused on receiving no more than $500 per month, the maximum allowable earnings while receiving benefits.

It seems that having a work/volunteer opportunity goes beyond the simple explanation of just 'working'. Rather, having that opportunity available also promotes a sense of community and connection. Clinton et al. (1998) and Drake (2005) suggest that being around people facilitates coping and competence, but also assists individuals with community adaptation. Therefore, the normalcy of having 'work' fosters many other skills and abilities, rather than just performing usual duties on a regular basis. Participants indicated that having work/volunteer opportunities were a source of social support; attending the physical location of the work site, the people or co-volunteers/workers, as well as the staff. Having those same opportunities also contributed to recovery in that they provided something structured to engage in, gave a sense of purpose, and also assisted when an individual was unwell mentally. Ultimately, participants seemed to view work/volunteer roles as a source of connectedness. The opportunity to engage in such activity, but also to be around people, provided a sense of connectedness. As many of the work/volunteer opportunities were at Connections Clubhouse, there was the added sense of community – where people could socialize, but also engage in their work/volunteerism.

Mental Health Services

The theme of mental health services was significant with both phases of data analysis. Specifically, the Recovery Assessment Scale statement, item #12 "I know that there are mental health services that do help me", had the most associations (12) with the Social Support Survey Instrument. This was one of the most surprising findings. I did not anticipate the research participants recognizing strong ties to the mental health system, or expressing that social support was provided by the mental health system. Despite the participants recognizing the mental health system as a source of support, participants did not state that

service providers were their peers. Rather, the participants had very clear ideas about who their peers were, which will be next discussed in the 'peers' section. In the Chapter Two literature review, I had suggested that one of the areas that individuals living with an SPMI are recovering from was the very mental health system the participants recognized as providing support and contributing to their recovery. This assertion was based on the history of mental health services, and treatment of individuals engaged in the mental health system.

I recognize that mental health services can be delivered from formal service providers such as Northern Health Authority's, Mental Health and Addictions Services, or community providers, such as non-profit community agencies or clubhouses and activity centers (informal services). However, participants did not discern between formal or informal mental health services. Rather, participants proposed the following to be inclusive of 'mental health services': case managers with the Northern Health Authority's Community Outreach and Assertive Services Team (COAST) and Community Acute Stabilization Team (CAST); doctors at COAST; psychiatrists; lifeskills support workers (through CMHA); ACE; and Connections Clubhouse.

As highlighted in Chapter Four, participants did not seem to draw a distinction between the various mental health service providers, but rather recognized they could access assistance. Participants mentioned the following types of assistance that they receive - gaining information or emotional support; general assistance; and receiving referrals and/or resources. Most important is that individuals feel a connection and receive the support and assistance that they request. Mason, Olmos-Gallo, Bacon, McQuilken, Henley, and Fisher (2004) found that having a bond and sense of connection to a service provider contributed to a consumer's sense of satisfaction with mental health services.

Some participants expressed dissatisfaction and recognized gaps pertaining to Northern Health Authority's, Mental Health and Addictions Services. The concerns and gaps will be discussed later in this chapter.

Peers

The theme of peers was significant within both phases of data analysis. In phase one, there were multiple statements from the Recovery Assessment Scale that captured the notion of 'peers', including: "I have people I can count on"; "Even when I don't believe in myself, other people do"; and "It is important to have a variety of friends". Participants had many ideas about peers, including who their peers were, roles of peers, the idea of peer-ship being reciprocal and perceived, as well as the function of having peers with mental illness. Participants explained that social support was often provided by peers, rather than family members or service providers. This does not appear to be supported by the literature, as it has been found that social support networks of people living with an SPMI are often dominated by family members and/or paid service providers (Bradshaw & Haddock, 1998; Pernice-Duca, 2005).

According to Baker et al. (1992), individuals living with an SPMI have fewer people dependent upon them for advice, support, and assistance. Provencher et al. (2002) further suggest that individuals living with an SPMI have limited experience establishing reciprocal relationships. Perhaps these are accurate assertions, but in this research participants indicated that an important aspect of having peers is also being a peer, indicating that they provide advice, support, and assistance to their peers. This finding is also in line with Tilden and Gaylen's (1987) social exchange theory, which suggests that human behavior is based on the exchange of mutually rewarding activities.

One of the most interesting points made was the importance of having peers who also live with a mental illness. Reasons that participants indicated this is helpful included: people can understand and maybe relate; decreased feelings of isolation or uniqueness; and simply being in the presence of others who live with a mental illness. Peer support programs aim to use the similar experiences of people so that guidance and assistance can be given from people who have had shared similar instances (Davidson, Chinman, Sells, & Rowe, 2006). From personal experience working in the mental health system, there seems to be limited access to a formal peer support program, which is only available to individuals involved in one particular facility. That said, perhaps Connections Clubhouse can be viewed as an informal peer support program.

A particular aspect of the theme peers was the acknowledgement of peers who also live with a mental illness. However, there seems to be limited literature with respect to people living with a mental illness valuing peers who also live with a mental illness, outside of the context of peer support. Peer support is described as people who have similar experiences and circumstances supporting each other (Onken et al., 2007). This connection with peers can often dissolve the feelings of uniqueness and isolation (Onken et al., 2007). Mezzina, Borg, Marin, Sells, Topor and Davidson (2006a) add that much strength and support is gained from people who also live with a mental illness. I find these points interesting because as service providers, we try to provide 'normal' or mainstream opportunities for people to engage. We try to move away from 'sheltered' experiences, and look for 'regular' opportunities in the community among the general population. Perhaps this is not what people want, and individuals would prefer to associate with people with similar experiences.

Connectedness

The inter-connectedness around the relationship between recovery and social support was highlighted when participants mentioned that having a connection to mental health services, a connection to work or volunteering, and a connection to peers was important to them. Thus, these connections serve many purposes, in that they create a sense of community, as well as a sense of belonging and purpose. Ultimately, a sense of connectedness, belonging, and purpose seemed critical to both an individual's recovery and social support. Anthony (1993) asserts this point in a convincing way: "Recovery is a deeply human experience, facilitated by the deeply human responses of others" (p. 160). Mezzina et al. (2006a) support Anthony's view, as well as my finding of connectedness, by remarking that having a sense of belonging, to a place or to a group, often occurred within the context of a similar-interest club, where friendships are formed based on similar interests.

According to the literature, connection involves integration and discovery of different roles one can play and engage in, with the end goal being to find belonging in a community (Bond et al., 2004; Jacobson & Greenley, 2001). By having the opportunity for social support, a sense of connection and community is facilitated (Pernice-Duca, 2005). Provencher et al. (2002) suggested that individuals living with an SPMI have limited social contact as a strategy to protect their vulnerable sense of self. According to the research participants, simply being around people was important, in that being in the presence of people served to support them, but also contributed to their recovery. The results from my research seem to contradict Provencher et al.'s finding, because participants did not seem to limit their social contact. Rather participants explained the importance of connection and

how they strive for social contact, instead of limiting their social interactions. Participants recognized the benefits of having that contact in place.

Participants acknowledged that by having a place to go, such as Connections Clubhouse, there has been the provision of a sense of belonging and community, but also an avenue for activities. Onken et al. (2007) suggest that the recovery process emphasizes social inclusion, as well as meaningful roles and the need to build inclusive communities. It seems that Connections Clubhouse may be a catalyst for friendships and socialization, even after Clubhouse hours. This is important, because connection and support should be available, and continue beyond usual 'work' hours such as those maintained by Connections Clubhouse. Onken et al. support this view, stating:

> "Supportive social relationships, circumstances, and opportunities must be in place for recovery to be fully actualized. Recovery relies on an environment that provides opportunities and resources for new or resumed social roles, engagement in relationships with others and meaningful integration in the larger society" (p. 16/17).

It seems that having access to an environment with activity and support is critical. Luckily, the participants involved in this research have this opportunity. However, my concern is that there are people who are not, or cannot, access such an environment for a variety of reasons.

Stigma

The fifth and final theme that emerged was stigma. This was the most interesting finding for me, as there was no question in either phase of the data collection that was related to stigma. Thus, on one hand, I was surprised that the theme of stigma emerged, but on the other hand, not surprised, given that this is the unfortunate actuality of living life with a mental illness. At first I was saddened that this is the reality for people who live with an SPMI, but as I thought about it, perhaps stigma can be viewed in a positive light, giving

strength and courage to challenge one's personal beliefs (internal stigma), and those embedded societal beliefs (societal stigma).

The emergent theme of stigma seemed to trickle in amidst both the common and unique themes as discussed in my diagram of the relationship between recovery and social support (see Figure 1, page 74). Mezzina, Davidson, Borg, Marin, Topor, and Sells (2006b) suggest that stigma is a social barrier to recovery. With respect to my research, stigma appeared to have a negative impact, but also moved people forward - on their recovery journey. For example, a person may not engage in or believe recovery is possible, due to living with a mental illness, for a variety of reasons. Or, a person may decide to challenge his or her beliefs of living with a mental illness (internal), and/or confront societal beliefs or stigmatizing attitudes (societal). With respect to social support, stigma and discrimination were present, but also shaped and defined how individuals viewed their social supports. For example, participants acknowledged that having peers who live with a mental illness is helpful and beneficial, because there is an established sense of understanding. People talked about the shame they experienced, when they were unwell, and did not want their friends to know. Therefore, there are both negative and positive impacts of stigma, depending on how the stigma is perceived by the individual.

Based on the literature I have suggested that recovery is from a host of different concerns, one aspect being the actual mental illness. Other areas of recovery may include: loss of family, relationships, friendships, home, job, self, hope, goals, or dreams; the mental health system; and stigma, both internal and societal.

The emergent theme of stigma highlighted examples of both internal and societal stigma. Internal stigma is about learning to cope with oneself. Societal stigma is about

learning to adapt, cope, and challenge/change/educate the community, as well as the larger society, riddled with stigma and discrimination.

Participants provided examples of both internal and societal stigma, but also of lateral discrimination, which I did not uncover during the literature review. According to the Center for Addiction and Mental Health (n.d.), stigma and discrimination often become internalized by people living with and SPMI. This internalized stigma can lead to the person believing negative things that other people and the media say about them, as well as having lower self-esteem due to feelings of guilt and shame because of living with a mental illness (Center for Addiction and Mental Health). It has been argued in the literature that the crucial first step towards recovery is overcoming internal stigma; one must look inside oneself, identify strengths, and learn not to be ashamed (Deegan, 2001; Leete, 1989). Participant Daniel, who describes himself as recovered, portrayed this beautifully when he explained:

> "It was hard for me to accept the fact that I wasn't Joe cool and it actually happened ...I denied it and denied it and told the doctor he was a goof all because I wouldn't accept the fact. Coulda been I was ashamed that I wasn't the super person everybody thought I was."

Societal stigma occurs "when elements of labeling, stereotyping, separation, status, loss, and discrimination occur together in a power situation that allows them" (Link & Phelan, 2001, p. 377). By having labels and stereotypes for different groups of people, stigmatizing attitudes become fixed and perpetuated. Therefore, it is no surprise when research suggests that stigma equates to limited opportunities for work, education, family, activity, housing, healthcare, or relationships (Center for Addiction and Mental Health, n.d.). Onken et al. (2007) argue that the mitigation of the oppressive nature of barriers imposed by society, or in other words stigma, so that individuals living with an SPMI can fully experience societal inclusion, is second order change. Second order change is when society

acknowledges, supports, and adopts a new way of thinking and behaving, where first order change has to do with the individual and the changes that he or she makes in him or herself (Onken et al.). As previously mentioned, the Canadian Medical Association released a report in 2008 and highlighted statistics of Canadians' stigmatizing attitudes. The Canadian Medical Association (2008) recognized this unacceptable reality by stating: "In some ways, mental illness is the final frontier of socially-acceptable discrimination" (p. 1).

Despite obvious levels of internal and societal stigma amongst the research participants, to their credit, many participants were pursuing and succeeding in several areas, including work, education, activity, and relationships. Perhaps this finding indicates that participants have a lower level of internal stigma, but are also challenging societal discrimination. Sibitz, Unger, Woppmann, Zidek, and Amering (2009) conducted a study examining stigma resistance (SR), which is an individual's capacity to counteract the stigma of mental illness. Their findings revealed that two thirds of the participants had high levels of SR, which resulted in higher levels of self-esteem, empowerment, and quality of life. Lower levels of SR resulted in higher levels of depression. The conclusion of their research suggested that the development of stigma resisting beliefs might contribute to an individual's recovery journey.

Although lateral discrimination was not discussed during the literature review, it emerged out of the theme of stigma. Lateral discrimination can be thought of as the harmful discrimination that is done to each other as a part of an already discriminated against group (Watson & Corrigan, in press). In other words, it is the hurtful attitudes or behaviors demonstrated towards a group of which one is a member. This particular finding was interesting, yet distressing, because I did not realize that members of such a stigmatized

group would feel that way about each other. Ideas about how to address all levels of stigma will be discussed in the 'implications for policy and practice' section.

Recovery

When I discussed the topic of recovery in the literature review, I suggested that people consider what exactly individuals are recovering from, as it is not solely the mental illness. Onken et al. (2007) support this notion, reiterating that "understanding recovery must include a discussion and definition of what people are recovering from and it is at this nexus that the large schism appears in the literature" (p. 10). There were three areas of recovery that I identified. Two of the three areas have already been discussed; the mental health system, as well as stigma (internal and societal). The third and final area that I identified involved loss, which recognized the loss of family, along with relationships, friendships, home, job, self, hope, goals, and dreams.

With respect to recovery and the area of loss, interestingly, participants did not seem to dwell on losses in their lives; thus loss was not a theme that emerged from the data. Several participants gave examples of losing friendships, but they seemed to be focused on their current life circumstances and drew from what experiences and resources they currently have available to them, rather than looking at what they used to have. Perhaps also because of how the interview guide was formed, there was no opportunity to retrospectively consider what had been lost due to living with an SPMI. That is not to negate the fact that many people have suffered painful losses of homes, careers, relationships, friendships, children, hopes, and dreams due to living with a mental illness, as discussed in the literature (Mosoff, 1997; Schiff, 2004; Tooth et al., 2003).

Recovery has been found to be a social process (Jacobsen & Greenley, 2001). Therefore, I was not surprised when the theme of connectedness emerged from the data. Topor, Borg, Mezzina, Sells, Marin and Davidson (2006) found that "social interaction is of importance to the recovery process, whether that interaction is with family and friends or clinicians and other professionals" (p. 35). The scope of my research is such that it did not capture specifically who supported a person, but this could be an area for future research.

Social Support

The literature pertaining to social support is extensive and comprehensive, but with respect to social support and people living with an SPMI, the literature is more limited. Studies have looked at objective counts of people who provide social support, and also acknowledged that support systems are generally smaller and/or less satisfactory for people who live with an SPMI (Bradshaw & Haddock, 1998; Clinton et al., 1998; Corrigan & Phelan, 2004; Pernice-Duca, 2005; Rogers et al., 2004; Sullivan & Poertner, 1989). However, I wanted the focus of my research to be two fold, in that I wanted to explore the relationship between recovery and social support, but also attempt to develop a definition of social support, based on the perspectives of individuals living with an SPMI – a definition which currently seems to be missing from the literature.

The literature highlights various attributes of social support, including emotional, instrumental/tangible, informational, affectionate, and positive social interaction (Hays et al., 1995; Langford et al., 1997). Emotional support includes such provisions as care, empathy, love, or trust, and is suggested to be the most important for the perception of conveyed support. Instrumental/tangible support is concrete assistance, such as the provision of tangible goods, services, or aids. Informational support is provided during times of stress or

to assist one to problem-solve. Affectionate support is physical support, such as a hug, or an expression of love or affection. Finally, positive social interaction includes having someone with whom to spend time. Various attributes of social support were described and defined by participants, but as per the literature, one particular attribute that was absent from this population's definition was affectionate support (Hays et al., 1995). Perhaps the interview guide was not structured in a way that elicited responses regarding this type of support.

Other areas that emerged from the data were the ideas of support being reciprocal and the importance of support being perceived. The literature suggests that reciprocity must be present for the support to continue (Langford et al., 1997). Within my research, it was portrayed that reciprocity is very important. And with respect to perceived support, it has been suggested that it is important for a person to perceive he or she is supported, whether or not this is the reality (Clinton et al., 1998; Sullivan & Poertner, 1989). I was not surprised when participants mentioned perceiving they were supported. I felt satisfied that my findings were consistent with previous research suggesting perception is important. I was surprised when participants did not mention objective numbers of people who provide support to them, which can also be thought of experienced support.

As presented in Chapter Four, the groundwork for a definition of social support has been developed, from the perspectives of individuals living with an SPMI as follows:

> The perception of having a system of family, friends, community mental health (formal or informal), work/volunteer opportunities, or community agencies, available to talk or engage in activities. The system is comprised of the whole network or team of support people. Having a system of social support can provide a reason to get out of bed in the morning, become or stay involved, improve daily activity, and keep one

active. Social support can act as a lifeline, provide reassurance, or create a sense of connectedness. Social support is provided during good times and bad times. Support can be provided when people are having a hard time relating or understanding what is going on, but also to have fun and engage in activities. Giving and receiving social support amongst peers with mental illness is important in that it gives the sense that 'I'm not the only one', and that people in similar situations can understand and relate to what is going on. It is important to support others, rather than solely receive support.

This is only the beginning of a definition, but could serve as a starting point for further development.

Chapter Six: Wrapping Up

Chapter Six will provide the conclusion to this research thesis. Final areas that will be addressed include the limitations of this study, implications for policy and practice, as well as suggestions for future research, and dissemination of the results. The chapter will end with concluding remarks.

Limitations

There are a number of limitations with respect to my thesis research. To conduct research with a population that lives with an SPMI can sometimes present a challenge, in that there may be inaccurate or incomplete responses on the scales or during the interviews. However, even among the general population, a researcher can experience inaccurate or incomplete participant reporting. I recognized and acknowledged that this research is using a constructivist approach, so that personal accounts are based on the reality of the individuals involved.

Due to non-probability sampling methods, and the small sample size, there may be problems with internal validity and therefore findings may not be generalizable (Rubin & Babbie, 2004). However, generalizability was not a goal of this exploratory research. Rather, exploration of the topic, and perhaps topics for future exploration, were more immediate motives.

Another limitation is that my research was conducted with participants who are fortunate enough to be socially connected, or have the potential to be socially connected. With that in mind, the results could look very different from the general psychiatric survivor population who may not have this opportunity, or accessibility, for connection with others.

As well, when I was conducting the research, I was on maternity leave from my supervisory role at CMHA. Upon my return to the workforce, I have not returned to CMHA. However, because participants knew of my role at CMHA, I was very aware, and gave acknowledgement to, the potential for participants to feel pressured to participate, or uncomfortable to participate, for fear of impact on their housing or lifeskills services, or even their membership at Connections Clubhouse. I tried to reassure participants that participation was completely voluntary and confidential in nature. In addition to participants possibly feeling obligated to participate, another limitation is that I have a history with the participants, through my years of service at CMHA. I knew the majority of the participants, either serving them directly in the housing or lifeskills programs, or through my regular visits to Connections Clubhouse. Thus I had prior knowledge of participants, and participants had prior knowledge of me as well.

As previously mentioned, the MOS: Social Support Survey Instrument was not developed specifically for individuals living with an SPMI. In fact, at the time of my research, there was no social support tool available that was designed specifically for this population. I chose the MOS: Social Support Survey Instrument based on the recommendation of an established researcher in this area, Dr. Jill Grant. In addition to querying if I selected the most suitable scales, I had to set the parameters regarding how I was going to execute the quantitative analysis, as there were no established guidelines available in the literature. It is also possible that my interview guide could have impacted, limited, or shaped my findings. In particular, I now query whether it was structured in the best way to develop a definition of social support, given that one particular attribute (affectionate support) was absent from the findings.

Finally, individuals who access Connections Clubhouse were not consulted about what research they felt would be most relevant and/or useful for their needs. Instead, I chose this topic on my own accord, based on my experience and familiarity with the literature, but without direct consultation or input from the people I served. Therefore, it can be perceived that this study was 'done to' the individuals, rather than 'done with' the individuals.

Implications for Policy and Practice

I have worked with adults living with an SPMI in a community setting for eight years, and have had the honour of learning from this very diverse group about what is important in life, as well as about recovery and social support. As a result there is potential to have an impact on policy and/or practice, stemming from my research findings.

The potential implications for policy include making it possible for policy makers to better understand the point of view of service recipients and to be more inclusive when making decisions about funding and programming. The individuals who access community services know what is working and what is not. The voices of these individuals should be sought, heard, and ultimately have an impact on the policies that shape practice. I believe that those receiving services should be consulted about the delivery of services.

It is my hope that this new clarity about the importance of social support for an individual's recovery could create a shift in funding, to create more, or simply maintain, opportunities for social support to occur. This in turn could lead to improved potential for individuals to engage in recovery. However, at this time of funding restraints and cuts, social supports (such as Connections Clubhouse and ACE) could potentially, in my view, erroneously be considered dispensable. According to the literature, it is more cost effective to

have someone supported in the community, than it is to support that same person as an in-patient in a hospital setting (Anthony et al., 1990).

In regard to impact on practice, if this research could be shared with Northern Health Authority's Mental Health and Addictions Services clinicians, then there may be the potential for a philosophical shift in service delivery, moving towards a recovery-oriented model. With a philosophical shift, the provision of service could look much different for individuals living with an SPMI, including: improving opportunities to work collaboratively between the individual and service provider; bringing people with similar experiences together, either in a social context or provider-consumer relationship; and focusing on people's skills and abilities, as well as assisting people to set and achieve realistic goals. I would argue that even if the organization did not make a philosophical shift, individual workers could adopt these service provision practices.

When participants shared their views about gaps and limitations of mental health services, it seemed like a good opportunity to include the concerns in the implications section. Participants recognized that social support is not always available, for example on weekends. This is an insightful observation, and perhaps there should be something in place - for mental health consumers after hours, such as an emergency service, accessible on evenings and weekends. As well, it was mentioned that a person does not necessarily meet criteria for either the service itself or a particular program within the service. Therefore, if a person is requesting assistance, but does not meet specific criteria, there should be another option available. And lastly, participants mentioned that the provision of service is not necessarily equitable. Perhaps a review of criteria could take place. This review should be transparent and clear, so that a person can understand the criteria for apparent inequities.

From the literature, Andresen et al. (2003) and Hatfield (1994) acknowledged that service providers are on the periphery while individuals take control of their lives and start on their journey of recovery. Sometimes service providers disengage from the service, assuming that the individual is no longer in need of assistance. Mindful of this, as service providers we should have the conversation with the service recipient to explore need and want for a particular service or program. However, as service providers, we are aware of the many structures that create barriers to accessing services, with multiple criteria, or limited availability of services, given lack of resources.

The last idea that I wish to address regarding implications for policy and practice is that of internal and societal stigma. Many sources have highlighted that the best way to challenge stigma is through education (Canadian Mental Health Commission, n.d.; CMHA, n.d.; US Surgeon General, 1999). The CMHA website gives concrete suggestions about how to fight stigma and discrimination, including: respond to stigmatizing material in the media by way of protest, as well as providing feedback and material containing accurate information to those responsible; speak up about stigma when someone misuses a psychiatric term; talk openly about mental illness, because when something is not talked about, it remains hidden, perpetuating the idea of shame; demand change from elected representatives, including eradicating the inadequate budgets for mental health services; and support local organizations that fight stigma and discrimination. These strategies can be framed as education. Education about mental illnesses could start with children in a school setting. As well, when service providers obtain their education, there could be education not only about mental illness, but also about how to combat the stigma and discrimination associated with mental illness. Challenging societal beliefs about mental illness is something that every

service provider can undertake in day-to-day practice. Education is so important in the fight against both internal and societal stigma.

Future Research

As a result of conducting this research, many ideas for future research have emerged. As already identified, this research was undertaken with individuals who are already connected socially. From my research, it has been shown that there is a link between social support and recovery. Therefore, future research could explore how a person living with an SPMI becomes connected to a social group.

Another idea may be to explore the notion of paid versus unpaid social support, by looking at who (service provider versus friend or family) is providing support, and if there are different types of support provided by either of the two groups and/or different impacts from the supports.

With respect to language, and the interchangeable use of the terms 'work' and 'volunteer' amongst study participants, I could not locate any research on this particular topic. Perhaps future research could explore this finding, and uncover the essence of the meaning of having regular work or volunteer opportunities.

As well, I believe that more research on the topic of mainstream versus sheltered opportunities would be helpful in directing the focus of service delivery and practice. It appears that there is limited literature with respect to this area, and I find this point interesting because as service providers, we try to provide 'normal' or mainstream opportunities for people to engage. Perhaps this is not what people want, but would rather connect with people with similar experiences.

Dissemination of Results

It is my intent that upon successfully completing my oral defense, and any subsequent changes to my written work, that the results of my research will be presented to the membership of Connections Clubhouse. I will also offer to make a presentation to Canadian Mental Health Association's Board of Directors. As well, a copy of my thesis will be provided to CMHA. I am hopeful that there will be opportunities to present the findings to other service users and providers connected with Northern Health Authority's, Mental Health and Addictions Services. It is also my intent to write about my research in academic and community publications.

Concluding Remarks

My intent with undertaking this research was to answer the question 'What is the relationship between recovery and social support?' In addition to the research question, three research objectives were also pursued: inform the qualitative draft interview guide based upon the results from phase one's data collection and analysis; explore the relationship between recovery and social support; and create a definition of social support from the perspectives of the research participants.

In phase one of data collection, there were 35 participants who answered two scales, which explored the two variables, recovery and social support. Upon data analysis, 11 significant statements were revealed, which directly informed the draft interview guide. Phase two of data collection included conducting 10 one-on-one interviews. The qualitative data was then analyzed using a thematic analysis. Through the emergent themes, the remaining two objectives were met.

A diagram was created to highlight the unique and common themes related to the two variables, recovery and social support. The common themes were used to answer, at least in part, the question of relationship. This research found that the relationship or interconnectedness between recovery and social support is captured in four overlapping themes: having work/volunteer opportunities; having access to mental health services (as defined by the service user); peers; and achieving a sense of connectedness.

Through the thematic analysis, an additional theme, stigma, emerged but did not necessarily contribute to description of the relationship between recovery and social support. Rather, the theme of stigma seemed to weave both within and throughout the two variables, recovery and social support. The finding of stigma was quite profound, as there were no questions related to stigma in either phase of data collection. However, facing stigma is the unfortunate actuality of living life with a mental illness. It is how the person interprets the stigma that is important; stigma can become a barrier or it can propel people forward on their recovery journey.

The third and final objective was to begin to develop a definition of social support based on the perspectives of individuals living with an SPMI, which may be helpful to address the present gap in the literature. Several aspects of a definition emerged, including the ideas of support being reciprocal and perceived. However, two areas that were present in the literature, but seemed to be missing from the consumer definition, included the aspect of affectionate support as well as objective numbers of people who provide support (experienced support).

Through conducting this research, it is believed that a better understanding of the relationship between the recovery process and social support was achieved which could

begin to inform policy, practice, and future research in community mental health. I hope that I have captured the voices of individuals living with an SPMI, and in turn, respectfully and honorably, highlighted the link between recovery and social support. Voice should be given to this marginalized population who live life everyday, despite dealing with the challenges of living with a serious and persistent mental illness. As psychiatric survivor Pat Capponi (2003) states, "Although the world is full of suffering, it is also full of overcoming it" (p. 117).

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Appendix A

Recovery and social support: What's the link?

Recovery Assessment Scale

You are going to read a list of statements that describe how people sometimes feel about themselves and their lives. Please read each statement carefully and indicate the response that best describes the extent to which you agree or disagree with the statement. For each of these statements, please indicate whether you strongly disagree (1), disagree (2), not sure (3), agree (4), or strongly agree (5) with these statements by circling the most appropriate number for each question.

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
1. I have a desire to succeed.	1	2	3	4	5
2. I have my own plan for how to stay or become well.	1	2	3	4	5
3. I have goals in life that I want to reach.	1	2	3	4	5
4. I believe I can meet my current personal goals.	1	2	3	4	5
5. I have a purpose in life.	1	2	3	4	5
6. Even when I don't care about myself, other people do.	1	2	3	4	5
7. I understand how to control the symptoms of my mental illness.	1	2	3	4	5
8. I can handle it if I get sick again.	1	2	3	4	5
9. I can identify what triggers the symptoms of my mental illness.	1	2	3	4	5
10. I can help myself become better.	1	2	3	4	5
11. Fear doesn't stop me from living the way I want to.	1	2	3	4	5
12. I know that there are mental health services that do help me.	1	2	3	4	5
13. There are things that I can do that help me deal with unwanted problems.	1	2	3	4	5

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
14. I can handle what happens in my life.	1	2	3	4	5
15. I like myself.	1	2	3	4	5
16. If people really knew me, they would like me.	1	2	3	4	5
17. I am a better person than before my experience with mental illness.	1	2	3	4	5
18. Although my symptoms may get worse, I know I can handle it.	1	2	3	4	5
19. If I keep trying, I will continue to get better.	1	2	3	4	5
20. I have an idea of who I want to become.	1	2	3	4	5
21. Things happen for a reason.	1	2	3	4	5
22. Something good will eventually happen.	1	2	3	4	5
23. I am the person most responsible for my own improvement.	1	2	3	4	5
24. I'm hopeful about my future.	1	2	3	4	5
25. I continue to have new interests.	1	2	3	4	5
26. It is important to have fun.	1	2	3	4	5
27. Coping with my mental illness is no longer the focus of my life.	1	2	3	4	5
28. My symptoms interfere less and less with my life.	1	2	3	4	5
29. My symptoms seem to e a problem for shorter periods of time each time they occur.	1	2	3	4	5
30. I know when to ask for help.	1	2	3	4	5
31. I am willing to ask for help.	1	2	3	4	5

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
32. I ask for help, when I need it.	1	2	3	4	5
33. Being able to work is important to me.	1	2	3	4	5
34. I know what helps me get better.	1	2	3	4	5
35. I can learn from my mistakes.	1	2	3	4	5
36. I can handle stress.	1	2	3	4	5
37. I have people I can count on.	1	2	3	4	5
38. I can identify the early warning signs of becoming sick.	1	2	3	4	5
39. Even when I don't believe in myself, other people do.	1	2	3	4	5
40. It is important to have a variety of friends.	1	2	3	4	5
41. It is important to have healthy habits.	1	2	3	4	5

Appendix B

Recovery and support: What's the link?

Medical Outcomes Study: Social Support Survey Instrument

People sometimes look to others for companionship, assistance, or other types of support.

How often is each of the following kinds of support available to you if you need it?

Please circle one number on each line.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Emotional/informational support					
Someone you can count on to listen to you when you need to talk	1	2	3	4	5
Someone to give you information to help you understand a situation	1	2	3	4	5
Someone to give you good advice about a crisis	1	2	3	4	5
Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
Someone whose advice you really want	1	2	3	4	5
Someone to share your most private worries and fears with	1	2	3	4	5
Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
Someone who understands your problems	1	2	3	4	5
Tangible support					
Someone to help you if you were confined to bed	1	2	3	4	5
Someone to take you to the doctor if you needed it	1	2	3	4	5
Someone to prepare your meals if you were unable to do it yourself	1	2	3	4	5
Someone to help with daily chores if you were sick	1	2	3	4	5

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Affectionate support					
Someone who shows you love and affection	1	2	3	4	5
Someone to love and make you feel wanted	1	2	3	4	5
Someone who hugs you	1	2	3	4	5
Positive social interaction					
Someone to have a good time with	1	2	3	4	5
Someone to get together with for relaxation	1	2	3	4	5
Someone to do something enjoyable with	1	2	3	4	5
Additional item					
Someone to do things with to help you get your mind off things	1	2	3	4	5

Appendix C

Recovery and support: What's the link?
Demographic Information

1. **How old are you?** _____ years

2. **Are you:** Male _____

   Female _____

3. **Are you working?** Yes _____

   No _____

* if yes, please provide details: _____

_____

4. **What is your marital status?**

   Single _____

   Dating _____

   Divorced _____

   Common law _____

   Widowed _____

   Married _____

   Separated _____

5. **What is your ethnic background?**

   Caucasian _____

   Aboriginal _____

   Asian _____

   Indo-Canadian _____

   Other _____

6. What is your mental illness diagnosis?

Schizophrenia _____

Bi-polar disorder _____

Schizo-affective disorder _____

Depression _____

Anxiety _____

Other _____

7. How long have you been diagnosed with a mental illness?

_____ months or _____ years

8. How long have you been a member of Connections Clubhouse?

_____ months or _____ years

9. How often do you come to Connections Clubhouse in a week?

_____ days each week

*If you come less than once/week, how many days do you come in a month?

_____ days each month

10. When you come to Connections Clubhouse how long do you stay?

_____ minutes or _____ hours

Appendix D

Erica Moore, BSc, MSW (candidate)
C/o University of Northern British Columbia
3333 University Way (BMO Building)
Prince George, BC
V2N 4Z9

Linda Doran
Executive Director
Canadian Mental Health Association
Prince George, BC
V2L 1R8

Dear Ms. Doran; November 15, 2008

Please accept the following letter as a request for your support for conducting my Master's of Social Work thesis research with the members at Canadian Mental Health Association's Connections Clubhouse.

As you are aware, I am currently working on a Master's of Social Work degree from UNBC. One of the requirements for successful completion of my Master's degree is a research thesis. My interest for my thesis is the relationship between recovery and social support for individuals living with a serious and persistent mental illness.

I am interested in testing the relationship between recovery and social support, hoping to highlight the importance of social support in an individual's recovery journey. I plan to do this by having research participants provide informed consent, basic demographic information, and complete two scales; one 41-item recovery assessment scale, and one 19-item social support scale. I also plan to conduct between five and seven one-on-one interviews. I would like to compensate scale participants with $10, and those who participate in the interviews with $20. Participation is completely voluntary, and individuals may withdraw from the study at any time.

Therefore, I would like to request your support to access research participants from Connections Clubhouse. I believe that the individuals who access Connections Clubhouse have invaluable expertise. In addition to seeking your support, I plan to seek approval from the membership of Connections Clubhouse.

I have included the participant information sheet, informed consent, copies of the two scales, and an interview guide with this letter for you to look over before making a decision.

If you have any questions, concerns, or comments, please do not hesitate to contact me via email: emoore0@unbc.ca or telephone: cell 250 640 7292.

Thank you for your time and consideration.

Respectfully,

Erica Moore, BSc, MSW Candidate, UNBC

Appendix E

Agency Support Letter

Prince George Branch
555 George Street
Prince George, B.C. V2L 1 R8
Tel (250) 564-8644
Fax (250) 564-6155
Toll Free 1-866-564-8644
www.cmhapg.ca

Erica Moore
C/o University of Northern British Columbia
3333 University Way (BMO Building)
Prince George, BC
V2N 4Z9

Dear Ms. Moore; November 17, 2008

On behalf of Canadian Mental Health Association, Prince George Branch, please accept the following letter of support for your proposed thesis research, which is a requirement for the successful completion of your Master's of Social Wok degree.

Canadian Mental Health Association would be pleased to support the research undertaken, with such an important population of people. CMHA is ultimately responsible for Connections Clubhouse, the location that you wish to collect your research's data. However, to honour the members of Connections Clubhouse, I request that you speak with the clubhouse membership to explain your proposed research and get the memberships' approval for the research to go ahead.

In regards to the issue of individuals being competent to provide informed consent, the majority of individuals who access Connections Clubhouse are competent to provide consent. However, if there are individuals who are incompetent to provide consent, as the executive director of CMHA, I will provide you awareness of those particular individuals.

As well, I support the utilization of the office space at Connections Clubhouse for the data collection.

I wish you the best of luck, and look forward to hearing about the results from your research.

Sincerely,

Linda J. Doran
Executive Director

Appendix F

Recovery and Social Support

Erica Moore, Master of Social Work Student from UNBC, would like to invite you to participate in research relating to mental health recovery and social support.

Your role: Approximately 30 minutes of your time to fill out two questionnaires and earn $10.

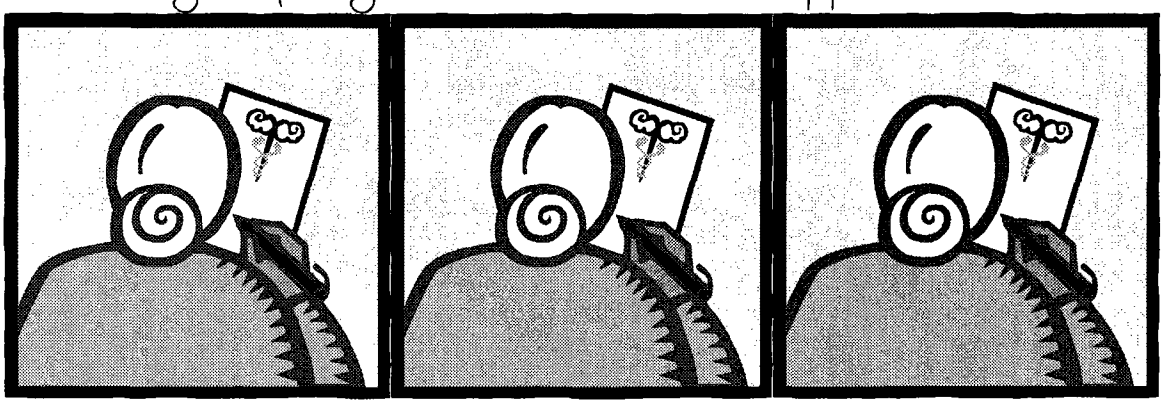
Date: TBA

Time: TBA

Place: Connections Clubhouse, 2734 Norwood Street

If you would like to participate, but have any questions, concerns, or require transportation, please contact Erica at 250 640 7292.

Thank you for your interest and support!



Appendix G

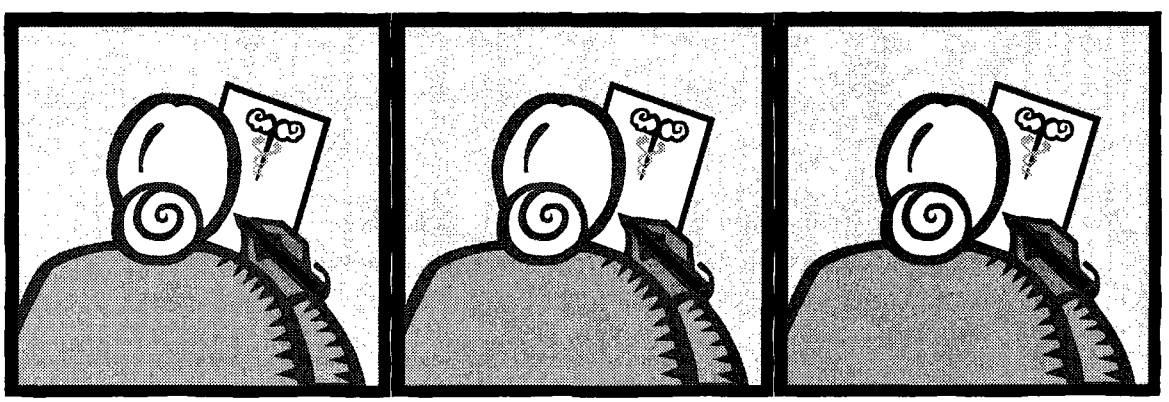
Recovery and Social Support

Erica Moore, Master of Social Work Student from UNBC, would like to invite you to participate in research relating to mental health recovery and social support.

Your role: Approximately 30-60 minutes of your time to participate in a one on one interview and earn $20.

If you are interested in doing an interview with Erica, please contact Erica at 250 640 7292 to schedule a convenient date, time, and location.

Thank you for your interest and support!



Appendix H

Recovery and social support: What's the link?

Original Interview Guide

1. Social support is the feeling of having a person, such as a friend, family member, spouse, or service provider, available to you. This person may provide emotional support such as someone to talk to, or loan you money, food, or tobacco, or help you problem solve. What does social support mean to you?

2. Does social support help you? Prompt: Does it help you with housing? Employment? Doing errands? Going to appointments? With money? Anything else?

3. Who provides social support to you? Can you describe what that person or persons do?

4. Is social support important to you? If so, why? If no, why?

5. Are there particular times when you seek out social support?

6. Is there a particular place you go to receive social support?

7. Is the social support you want or need always available to you? Can you provide examples?

8. Is there anything else you would like to tell me about your experience getting or not getting social support?

Appendix I

Recovery and social support: What's the link?

Revised Interview Guide

1. I am going to ask you about your personal beliefs. Please let me know what you think about this statement by stating yes or no and why:

Do you have a desire to succeed?
Do you like yourself?
Do you continue to get better?
Do things happen for a reason?
Does something good eventually happen?

2. What does recovery mean to you? Prompt: What is important to your recovery? Does social support play a role in your recovery? When you have been ill, what has helped you? How do you know when you are unwell mentally?

3. Tell me about your involvement with mental health services. Prompt: Do mental health services help you? If so, why? If not, why not?

4. Do you know when to ask for help? If so, do you seek that help when needed? Who do you ask for help? Do you receive the help that you need?

5. What does social support mean to you?

6. Who provides social support to you? Can you describe what that person or people do?

7. Does social support help you? Prompt: Does it help you with housing? Employment? Doing errands? Going to appointments? With money? (management or loan) Problems? Information? Anything else?

8. Is social support important to you? If so, why? If not, why not?

9. Are there particular times when you seek out social support?

10. Is there a particular place you go to receive social support?

11. Is the social support you want or need always available to you? Can you provide examples?

12. Tell me about your friends. Prompt: Do you have a variety of friends? Do you have people you can count on? Do other people believe in you, even when you don't believe in yourself?

13. Is having fun important to you? What do you do for fun? With whom?

14. Is there anything else you would like to tell me about your experience getting or not getting social support?

15. Is there anything else you would like to tell me about your experience of recovery?

Appendix J

UNBC Research Ethics Board Approval

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

RESEARCH ETHICS BOARD

MEMORANDUM

To: Erica Moore
CC: Dawn Hemingway

From: Henry Harder, Chair
Research Ethics Board

Date: November 27, 2008

Re: **E2008.1118.194**
Recovery and social support: What's the link?

Thank you for submitting the above-noted request to the Research Ethics Board. Your proposal has been approved.

We are pleased to issue approval for the above named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board.

Good luck with your research.

Sincerely,

Henry Harder

Appendix K

Recovery and support: What's the link?

Scale Information Sheet

Researcher's Name: Erica Moore, BSc, MSW Candidate

Address: c/o University of Northern BC
3333 University Way (BMO Building),
Prince George, BC V2N 4Z9

Phone: cell 250 640 7292 **E-mail:** emoore0@unbc.ca

Supervisor's Name: Dawn Hemingway, MSc, MSW, RSW
Associate Professor
School of Social Work, UNBC

Phone: 250 960 5694 **E-mail:** hemingwa@unbc.ca

Title of Thesis: Recovery and support: What's the link?

Purpose of Research: The purpose of this research study is to determine if there is a relationship between recovery and social support for people living with a serious and persistent mental illness.

Participants will be:

*adults (over 19 years of age)
*living with a serious and persistent mental illness
*have difficulties with employment, education, housing, or relationships because of the illness
*members of Connections Clubhouse

Role of Participants: Your role as a research participant is to complete two questionnaires, one with 41 questions and one with 19 questions. You will also be asked other information such as your age, marital status, and participation at Connections Clubhouse. We ask that you answer the questions and provide information based on your own personal beliefs and experiences. There are no right or wrong answers. This will take approximately thirty minutes of your time.

Compensation: You will be compensated for your time, expertise, and input by receiving $10 cash.

****Your participation is completely voluntary. You may withdraw your participation at any time. You will still be compensated. If you withdraw your participation, it will in no way affect your membership, participation, or access to Connections Clubhouse, nor your services from CMHA.****

Anonymity: The questionnaires that you complete will not have any identifying information on them, and therefore will be anonymous. All questionnaire answers from everyone in the study will be combined so that no one's individual answers are identifiable.

Confidentiality: There will be no identifying information on your questionnaires. Questionnaire answers will be viewed by Erica Moore (researcher) and Dawn Hemingway (supervisor).

Potential Risks: There is no deception being used in this study. Some questions may be sensitive in nature or cause emotional responses. Phone numbers for Northern Health Authority, Mental Health and Addictions Services case managers, as well as the Community Response Unit, will be made available to you in case you feel the need for follow-up support.

Potential Benefits: It is hoped that your participation in this research study will highlight the importance of social support in recovery for serious and persistent mental illness, offering valuable information for potentially improved community services.

Storage of Information: Information provided by you will be stored in a locked filing cabinet in the office of the researcher's academic supervisor. The researcher and supervisor will be the only people who have access to the locked cabinet. Questionnaire answers will be inputted into a password protected file on the researcher's computer. Questionnaires will be shredded two years after the thesis is successfully defended.

Sharing of Research Results: The researcher will present the study findings at Connections Clubhouse. A written copy of the study will also be available to Connections Clubhouse members. The research will be used for the completion of a Master's degree thesis, and a copy will be available at the UNBC library. The research may also be presented to other service users and providers, and written about in academic or community publications.

For More Information: If you have any questions regarding this research study, please do not hesitate to contact Erica Moore at 250 640 7292 (researcher) or Dawn Hemingway at 250 960 5694 (supervisor), or the Vice President of Research, UNBC at 250 960 5820.

Please direct any complaints about this project to UNBC's Office of Research at 250 960 5820 or by email: reb@unbc.ca

Appendix L

Recovery and support: What's the link?

Interview Information Sheet

Researcher's Name: Erica Moore, BSc, MSW Candidate

Address: c/o University of Northern BC
3333 University Way (BMO Building),
Prince George, BC V2N 4Z9

Phone: cell 250 640 7292 **E-mail:** emoore0@unbc.ca

Supervisor's Name: Dawn Hemingway, MSc, MSW, RSW
Associate Professor
School of Social Work, UNBC

Phone: 250 960 5694 **E-mail:** hemingwa@unbc.ca

Title of Thesis: Recovery and support: What's the link?

Purpose of Research: The purpose of this research study is to determine if there is a relationship between recovery and social support for people living with a serious and persistent mental illness.

Participants will be:

*adults (over 19 years of age)
*living with a serious and persistent mental illness
*have difficulties with employment, education, housing, or relationships because of the illness
*members of Connections Clubhouse

Role of Participants: Your role as a research participant is to complete a one-on-one, semi structured, recorded interview with the researcher. We ask that you answer the questions and provide information based on your own personal beliefs and experiences. There are no right or wrong answers. This will take approximately thirty to sixty minutes of your time.

Compensation: You will be compensated for your time, expertise, and input by receiving $20 cash.

****Your participation is completely voluntary. You may withdraw your participation at any time. You will still be compensated. If you withdraw your participation, it will in no way affect your membership, participation, or access to Connections Clubhouse, nor your services from CMHA..****

Anonymity: The interview that you complete will not have any identifying information; you will be referred to by a fictitious name, and therefore will be anonymous. All interview information from everyone in the study will be combined so that individual interview answers will not be identifiable.

Confidentiality: There will be no identifying information on your interview. Interview transcripts will be viewed by Erica Moore (researcher) and Dawn Hemingway (supervisor).

Potential Risks: There is no deception being used in this study. Some questions may be sensitive in nature or cause emotional responses. Phone numbers for Northern Health Authority, Mental Health and Addictions Services case managers, as well as the Community Response Unit, will be made available to you in case you feel the need for follow-up support.

Potential Benefits: It is hoped that your participation in this research study will highlight the importance of social support in recovery for serious and persistent mental illness, offering valuable information for potentially improved community services.

Storage of Information: Information provided by you will be stored in a locked filing cabinet in the office of the researcher's academic supervisor. The research and supervisor will be the only people who have access to the locked cabinet. Interview transcripts will be shredded and audiotapes will be cut up two years after the thesis is successfully completed.

Sharing of Research Results: The researcher will present the study findings at Connections Clubhouse. A written copy of the study will also be available to Connections Clubhouse members. The research will be used for the completion of a Master's degree thesis, and a copy will be available at the UNBC library. The research may also be presented to other service users and providers, and written about in academic or community publications.

For More Information: If you have any questions regarding this research study, please do not hesitate to contact Erica Moore at 250 640 7292 (researcher) or Dawn Hemingway at 250 960 5694 (supervisor), or the Vice President of Research, UNBC at 250 960 5820.

Please direct any complaints about this project to UNBC's Office of Research at 250 960 5820 or by email: reb@unbc.ca

Appendix M

Recovery and support: What's the link?

Scale Informed Consent Form

Please circle your responses to the following questions:

Do you understand that you have been asked to be in a research study?	**Yes**	**No**
Have you received and read a copy of the study information sheet?	**Yes**	**No**
Do you understand the benefits and risks involved in participating in this study?	**Yes**	**No**
Have you had an opportunity to ask questions and discuss this study?	**Yes**	**No**
Do you understand the conditions of your participation? And that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason for doing so.	**Yes**	**No**
Have the issues of confidentiality and anonymity been explained to you?	**Yes**	**No**
Do you understand who will have access to the information you provide?	**Yes**	**No**

This study was explained to me by: _____
Name

My signature indicates that I agree to participate in this study.

_____	_____	_____
Name of Research Participant	Signature of Research Participant	Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____
Signature of Researcher	Date

*A copy of this consent is to be provided to both the participant and researcher.

Appendix N

Recovery and support: What's the link?

Interview Informed Consent Form

Please circle your responses to the following questions:

Do you understand that you have been asked to be in a research study?	**Yes**	**No**
Have you received and read a copy of the study information sheet?	**Yes**	**No**
Do you understand that the research interview will be recorded?	**Yes**	**No**
Do you understand the benefits and risks involved in participating in this study?	**Yes**	**No**
Have you had an opportunity to ask questions and discuss this study?	**Yes**	**No**
Do you understand the conditions of your participation? And that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason for doing so.	**Yes**	**No**
Have the issues of confidentiality and anonymity been explained to you?	**Yes**	**No**
Do you understand who will have access to the information you provide?	**Yes**	**No**

This study was explained to me by: _____
Name

I give permission for the researcher to use quotes from my interview, provided I am not named. I will be (a) provided a fictitious name, or (b) would like to be referred to as _____, to protect my real identity.

My signature indicates that I agree to participate in this study.

_____	_____	_____
Name of Research Participant	Signature of Research Participant	Date

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____	_____
Signature of Researcher	Date

*A copy of this consent is to be provided to both the participant and researcher.

Appendix O

Demographic Information for Participants

Length of time since mental illness diagnosis

Length of time since diagnosis	Number of Phase One Participants (n=34)	Percentage of Phase One Participants (n=34)	Number of Phase Two Participants (n=10)	Percentage of Phase Two Participants (n=10)
> 1 year	1	2.9%	0	0%
2 to 5 years	5	14.7%	0	0%
6 to10 years	7	20.6%	2	20%
11 to 20 years	12	35.3%	4	40%
21 to 30 years	7	20.6%	3	30%
< 31 years	2	5.9%	1	10%

Length of membership at Connections Clubhouse

Length of membership	Number of Phase One Participants (n=35)	Percentage of Phase One Participants (n=35)	Number of Phase Two Participants (n=10)	Percentage of Phase Two Participants (n=10)
< 1 year	12	34.3%	1	10%
2 to 5 years	7	20%	4	40%
6 to10 years	5	14.3%	0	0%
11 to 15 years	4	11.4%	2	20%
16 to 20 years	1	2.9%	1	10%
> 21 years	6	17.1%	2	20%

Frequency of participation at Connections Clubhouse

Frequency of participation	Number of Phase One Participants (n=35)	Percentage of Phase One Participants (n=35)	Number of Phase Two Participants (n=10)	Percentage of Phase Two Participants (n=10)
3 days/month	1	2.9%	0	0%
1 day/ week	7	20%	1	10%
1 – 2 days/week	1	2.9%	0	0%
2 days/week	9	25.7%	2	20%
2 - 3 days/week	3	8.6%	0	0%
3 days/week	3	8.6%	3	30%
3 – 4 days/week	2	5.7%	2	20%
4 days/week	5	14.3%	1	10%
4 – 5 days/week	0	0%	1	10%
5 days/week	4	11.4%	0	0%

Duration of stay during participation at Connections Clubhouse

Duration of stay (hours)	Number of Phase One Participants (n=35)	Percentage of Phase One Participants (n=35)	Number of Phase Two Participants (n=10)	Percentage of Phase Two Participants (n=10)
< 1	0	0%	0	0%
1	3	8.6%	1	10%
2	10	28.6%	2	20%
3	9	25.7%	3	30%
4	8	22.8%	2	20%
5	2	5.7%	1	10%
<5	3	8.6%	1	10%

Appendix P

Significant Chi Squares
(probability ≤ .050)

The following appendix highlights the significant Recovery Assessment Scale statements (item number refers to the placement in the 41-item scale), with their associated p value and type of social support, as indicated by the Social Support Survey Instrument item. Please refer to footnote for legend.

		p-value
1. I have a desire to succeed.		
* Someone to give you good advice about a crisis	(E/I)	.008
* Someone to confide in or talk about yourself and your problems	(E/I)	.050
* Someone to share your most private worries and fears with	(E/I)	.000
* Someone to turn to for suggestions about how to deal with a personal problem	(E/I)	.000
* Someone to do something enjoyable with	(PSI)	.008
12. I know that there are mental health services that do help me.		
* Someone you can count on to listen to you when you need to talk	(E/I)	.006
* Someone to give you information to help you understand a situation	(E/I)	.000
* Someone to give you good advice about a crisis	(E/I)	.047
* Someone to confide in or talk about yourself and your problems	(E/I)	.009
* Someone to take you to the doctor if you needed it	(T)	.032
* Someone to love and make you feel wanted	(A)	.002
* Someone to have a good time with	(PSI)	.018
* Someone to get together with for relaxation	(PSI)	.011
* Someone to do something enjoyable with	(PSI)	.046
* Someone to do things with to help you get your mind off things	(AI)	.001
15. I like myself.		
* Someone to give you information to help you understand a situation	(E/I)	.000
* Someone to take you to the doctor if you needed it	(T)	.008
* Someone to prepare meals if you were unable to do it yourself	(T)	.012
* Someone to have a good time with	(PSI)	.003
* Someone to get together with for relaxation	(PSI)	.001
* Someone to do something enjoyable with	(PSI)	.006
* Someone to do things with to help you get your mind off things	(AI)	.005

E/I – emotional/information support
T – tangible support
A – affectionate support
PSI – positive social interaction
AI – additional item

19. If I keep trying, I will continue to get better.

* Someone you can count on to listen to you when you need to talk	(E/I)	.000
* Someone to give you good advice about a crisis	(E/I)	.001
* Someone to have a good time with	(PSI)	.002
* Someone to get together with for relaxation	(PSI)	.004
* Someone to do something enjoyable with	(PSI)	.029

21. Things happen for a reason.

* Someone you can count on to listen to you when you need to talk	(E/I)	.017
* Someone to take you to the doctor if you needed it	(T)	.026
* Someone who shows you love and affection	(A)	.038
* Someone to love and make you feel wanted	(A)	.035
* Someone to do something enjoyable with	(PSI)	.010

22. Something good will eventually happen.

* Someone to give you information to help you understand a situation	(E/I)	.008
* Someone to confide in or talk about yourself and your problems	(E/I)	.004
* Someone to share your most private worries and fears with	(E/I)	.036
* Someone to turn to for suggestions about how to deal with a personal problem	(E/I)	.011
* Someone to do things with to help you get your mind off things	(AI)	.029

26. It is important to have fun.

* Someone to give you information to help you understand a situation	(E/I)	.000
* Someone to confide in or talk about yourself and your problems	(E/I)	.045
* Someone to take you to the doctor if you needed it	(T)	.025
* Someone to have a good time with	(PSI)	.038
* Someone to do things with to help you get your mind off things	(AI)	.002

E/I – emotional/information support
PSI – positive social interaction
T – tangible support
AI – additional item
A – affectionate support

30. I know when to ask for help.

* Someone to give you information to help you understand a situation	(E/I)	.009
* Someone to confide in or talk about yourself and your problems	(E/I)	.026
* Someone to take you to the doctor if you needed it	(T)	.030
* Someone to have a good time with	(PSI)	.042
* Someone to do something enjoyable with	(PSI)	.017
* Someone to do things with to help you get your mind off things	(AI)	.021

37. I have people I can count on.

* Someone you can count on to listen to you when you need to talk	(E/I)	.000
* Someone to give you information to help you understand a situation	(E/I)	.000
* Someone to give you good advice about a crisis	(E/I)	.001
* Someone to take you to the doctor if you needed it	(T)	.001
* Someone to have a good time with	(PSI)	.009
* Someone to do things with to help you get your mind off things	(AI)	.011

39. Even when I don't believe in myself, other people do.

* Someone to give you information to help you understand a situation	(E/I)	.000
* Someone to give you good advice about a crisis	(E/I)	.023
* Someone to share your most private worries and fears with	(E/I)	.030
* Someone to prepare you meals if you were unable to do it yourself	(T)	.019
* Someone to do things with to help you get your mind off things	(AI)	.036

40. It is important to have a variety of friends.

* Someone to give you information to help you understand a situation	(E/I)	.000
* Someone to give you good advice about a crisis	(E/I)	.048
* Someone to love and make you feel wanted	(A)	.006
* Someone to have a good time with	(PSI)	.016
* Someone to get together with for relaxation	(PSI)	.032
* Someone to do things with to help you get your mind off things	(AI)	.003

E/I – emotional/information support T – tangible support A – affectionate support
PSI – positive social interaction AI – additional item